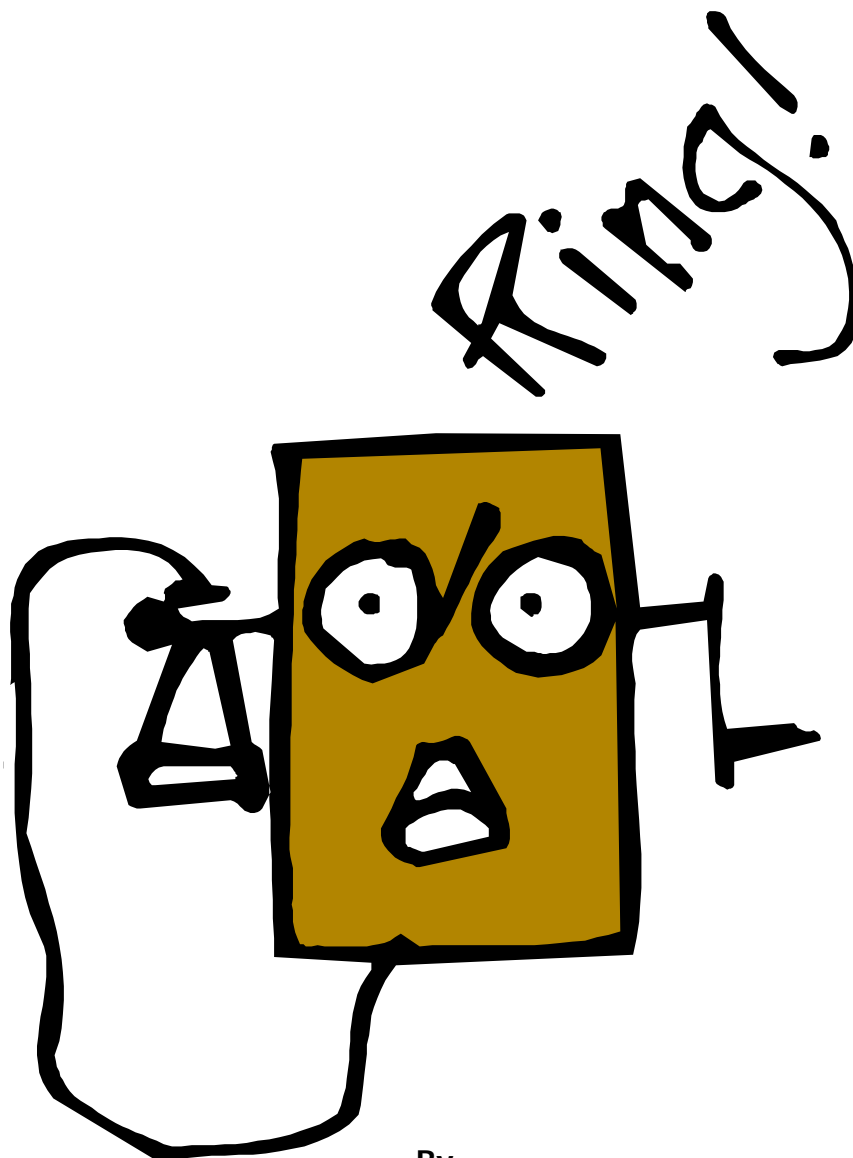
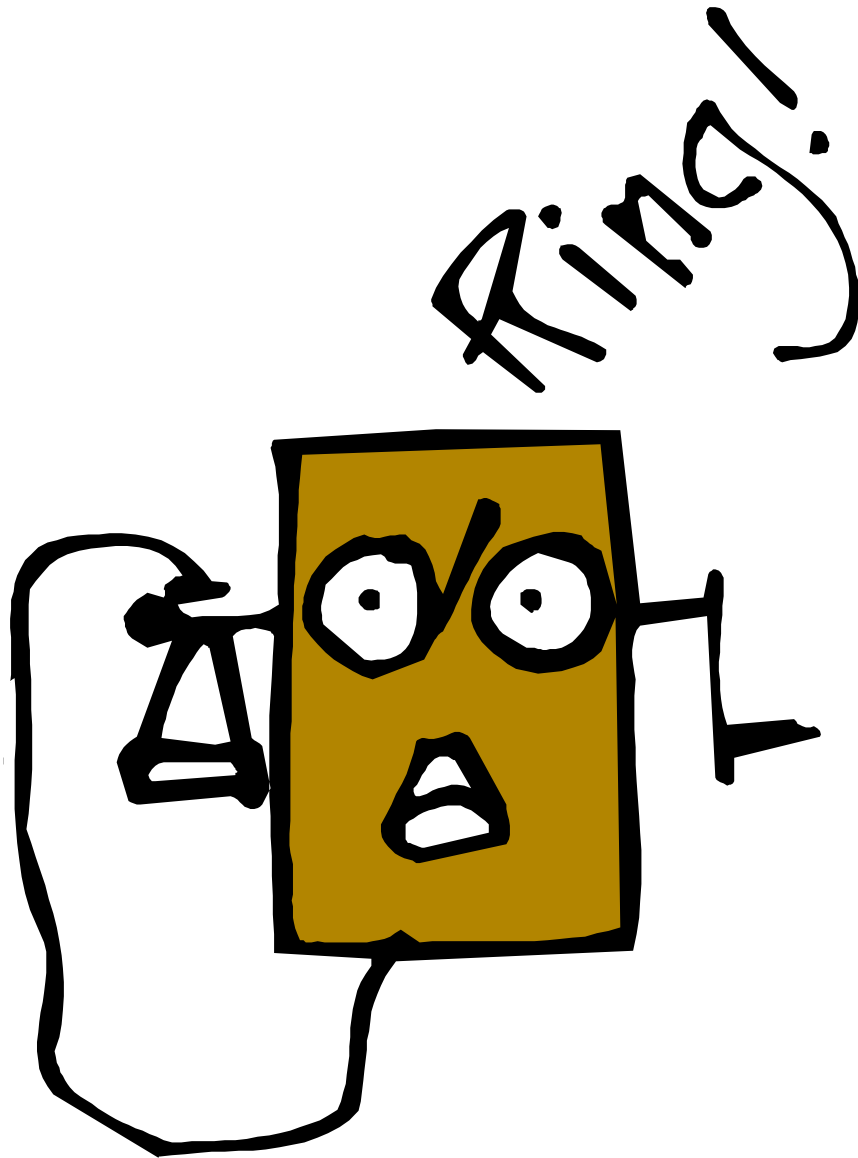


Advanced Communication Skills Curriculum Module



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Advanced Communication Skills Curriculum Module



Introduction

Advanced Communication Skills Curriculum Module

Directions for Use

Advanced Communication Skills is a curriculum module that has been prepared for two groups of people. First, the instructors, for whom we wish to provide a curriculum that can be used to complement their teaching skills and help them to educate nurse aides to remain knowledgeable, efficient, and caring. Second, the nurse aides, for whom we wish to provide the knowledge and skills necessary to remain competent and current in their provision of care.

Curriculum Pages

Each objective has been featured on a single page divided into two areas – Content Area and Instructor Notes.

- The “Content” area included in each part of the curriculum module outlines the lecture information to be covered in order to meet the objective. Handouts, written activities, discussions, and overheads complimenting each part of the curriculum module are also included.
- The “Notes” area for each part of the curriculum module includes a blank area specially designed for instructor notes. Instructors may choose to write notes beforehand, during class, or afterwards. The notes may serve as reminders for the instructor or may include additional content or examples.

Overhead Transparencies

Each of the three parts of the curriculum module contains a set of overhead transparencies. Each transparency corresponds with a specific objective or objectives and includes information gleaned from curriculum pages. Each transparency is numbered and corresponds with the curriculum content. Even though use of overhead transparencies by the instructor is optional, their use may be an effective teaching tool for nurse aides who are visual learners.

Handouts

A set of handouts for each part of the curriculum module is included. Each handout is numbered and corresponds with specific content. Handouts include information gleaned from each of the three parts of the curriculum module. The master copy of each handout should be duplicated and distributed to each nurse aide at the appropriate time during the lecture sequence. Participants should be encouraged to complete appropriate portions of handouts, based on information provided during lecture.

Written Activities

Written learning activities are designed to enhance understanding of the content included in the curriculum module. Completion of each written activity requires the application of concepts learned by the health care provider.

Each written activity corresponds to a specific objective or objectives and is coded with a number corresponding with curriculum content. A master copy of each written activity and an instructor key (when applicable) are included. The master copy of each written activity should be duplicated and distributed to each health care provider at the appropriate time during the lecture sequence.

Group Discussions

Group discussions are done after each health care provider has completed written activity worksheets and are based on the answers to the worksheets. Group discussions are facilitated by the instructor and allow the health care providers to voluntarily answer the questions on the written activity worksheets.

Advanced Communication Skills Syllabus

Description:

Advanced Communication Skills is a curriculum module designed for the health care provider employed in a variety of health care settings. Good communication skills do not just happen. Saying the right thing at the appropriate time requires specific knowledge, skills, and effort. A health care provider often provides care to a variety of people – people from different cultures with distinct life experiences and unique needs. Situational communication, a style of communication skills dealing with a variety of affective conditions, will be useful not only in the health care institution, but also advantageous when the health care provider is “ off the clock.”

Objectives:

1. Identify the key elements in the communication process.
2. Describe the characteristics of a good listener.
3. Outline the importance of understanding nonverbal communication while communicating with a resident/patient.
4. Contrast therapeutic and non-therapeutic communication techniques.
5. Select appropriate communication techniques in unique health care situations:
 - a. caring for an anxious resident/patient
 - b. caring for a depressed resident/patient
 - c. caring for a resident/patient with delirium
 - d. caring for a hostile resident/patient
 - e. caring for an unconscious/comatose resident/patient
6. Identify appropriate communication techniques when caring for the resident/patient facing death.
7. Recognize the special communication techniques used when working with a resident/patient with Alzheimer’s disease.
8. Define culture, ethnicity, and race.
9. Define the term subculture and describe different subcultures that are a part of American culture.

10. List cultural building blocks and cultural stumbling blocks when working with people from other cultures.
11. Describe transcultural nursing and provide examples of its use when relating to residents/patients from different subcultures.
12. Apply culturally appropriate verbal and nonverbal communication techniques when caring for members of the African American, Native American, Asian American, and Latino subcultures.
13. Describe the culture of the healthcare system in our country & how it may conflict with values & beliefs of other cultures.

Teaching Methods:

- Lecture;
- Overhead Transparencies (Optional);
- Worksheets; and
- Class Discussion

Method of Evaluation:

In order to meet requirements for the curriculum module, the health care provider must:

- Attend the entire class;
- Participate in class discussions;
- Complete each of the four worksheets;
- Pass the "closed book" written test with a minimum grade of 80.

VOCABULARY

For

***ADVANCED
COMMUNICATION***

Advanced Communication Skills Curriculum Module

Vocabulary

<u>Affective touch</u>	personal contact that is used to show concern or affection.
<u>Alzheimer's disease</u>	a progressive, deteriorating brain disorder.
<u>Anxiety</u>	is a feeling of uneasiness or dread that occurs as a response to a perceived threat.
<u>Belittle</u>	to make someone feel less than what he/she truly is or to make feel unimportant.
<u>Body language</u>	behaviors associated with nonverbal communication that involve body parts, movement, and presentation of self to the world.
<u>Comfort zone</u>	the area just inside a person's personal space, that when entered by another person, does not cause distress for the person.
<u>Communication</u>	is a continuous, simultaneous, and reciprocal exchange or sharing of information involving at least two people.
<u>Context</u>	the conditions or location in which communication occurs.
<u>Culture</u>	is a view of the world as well as a set of values, beliefs, and traditions that are handed down from generation to generation.
<u>Delirium</u>	a sudden, temporary state of confusion.
<u>Ethnicity</u>	is the bond or kinship people feel with their country of birth or place of ancestral origin.

<u>Eye contact</u>	the act of one person directly looking into the eyes of another person.
<u>Feedback</u>	during communication, verbal and nonverbal evidence that the receiver has received and understood the message sent.
<u>Gait</u>	way a person holds the body while walking.
<u>Gestures</u>	movement of the arms, legs, head, or body to express meaning.
<u>Grief</u>	a loss involving someone or something that has a special meaning or significance to another.
<u>Hostile</u>	the act of feeling or showing hatred or malice towards someone or something.
<u>Kinesics</u>	body language that includes eye contact, facial expressions, posture/gait, and gestures.
<u>Listening</u>	the process of attending to and becoming involved in what is said by another person or persons.
<u>Message</u>	during communication, the actual information sent by the sender to the receiver, for example a speech, interview, telephone conversation, or end of shift report.
<u>Non-therapeutic</u>	using words and gestures that do not promote a person's physical and emotional well-being.
<u>Nonverbal Communication</u>	the exchange of information without using words.
<u>Paralanguage</u>	all vocal sounds (not words) made during a verbal exchange.

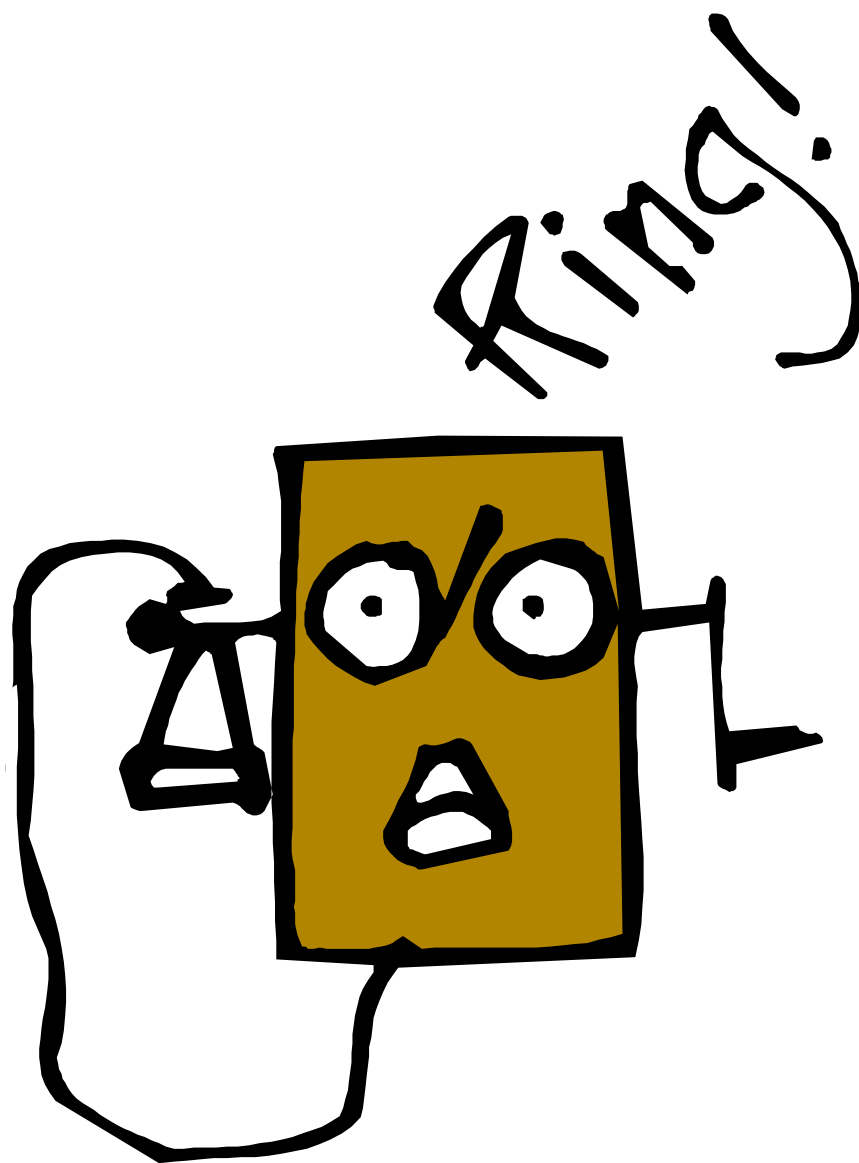
<u>Paraphrasing</u>	to say in other words or another way.
<u>Patronize</u>	to look down upon or to talk down to.
<u>Personal space</u>	a private zone or “bubble” around a person’s body that is viewed as an extension of his/herself and belongs to him/her.
<u>Posture</u>	way a person holds the body while standing still.
<u>Proxemics</u>	the use of space when communicating.
<u>Race</u>	biologic variation.
<u>Receiver</u>	during communication, the person that receives, translates, and makes a decision about a message sent by the sender.
<u>Sender</u>	(or source) during communication, the person that prepares and sends a message to a receiver.
<u>Sensory channel</u>	(in communication), the way that a message is being sent and may target one or more of the receiver’s senses (vision, hearing, touching).
<u>Silence</u>	the act of remaining quiet.
<u>Subculture</u>	a unique cultural group that coexists with a dominant culture.
<u>Task-oriented touch</u>	personal contact that is needed to perform nursing tasks.
<u>Therapeutic Communication</u>	the art of using words and gestures to promote a person’s physical and emotional well-being.

Touch to cause a part of the body, usually a hand, to come in contact with another object or person.

Transcultural nursing care nursing care provided within the context of another's culture.

Unconscious (or comatose) a person that cannot be aroused and does not respond to stimuli.

Advanced Communication Skills Curriculum Module



Part One

Objective 1: I identify the key elements in the communication process.

<u>Content</u>	<u>Notes</u>
<i>Handout - Distribute Handout #1</i>	
<i>Overhead - Show Overhead #1</i>	
Communication is an exchange or sharing of information involving at least two people.	
Communication is continuous, simultaneous, and reciprocal.	
People who communicate receive and send messages through verbal and nonverbal means	
<i>Overhead - Show Overhead #2</i>	
<u>Elements of communication</u>	
<ul style="list-style-type: none">• Sender (or source) - the person that prepares and sends a message to a receiver• Receiver - the person that receives, translates, and makes a decision about a message sent by the sender• Message - the actual information sent by the sender to the receiver, for example a speech, interview, telephone conversation, or end of shift report• Sensory channel - the way that a message is being sent and may target one or more of the receiver's senses (vision, hearing, touching), for example, the sender may use the receiver's senses of vision and hearing to demonstrate a skill• Feedback - verbal and nonverbal evidence that the receiver has received and understood the message sent, for example, a nod of the head or laughter• Context - the conditions or location in which communication occurs, for example, a noisy room or a very quiet church	

Objective 1: I identify the key elements in the communication process.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead - Show Overhead #3</i></p> <p><u>Messages sent and messages received are influenced by:</u></p> <ul style="list-style-type: none">• Knowledge• Past experiences• Feelings• Position of the individual in the relationship, for example the person is a resident/patient, health care provider, or the President of a country	

Objective 2: Describe the characteristics of a good listener.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #4</i></p> <p><u>Listening</u></p> <p>Defined – the process of attending to and becoming involved in what is said by another person or persons.</p> <p>Involves more than just hearing what is said, but also involves interpreting what is heard</p> <p><i>Overhead – Show Overhead #5</i></p> <p><u>A Good Listener</u></p> <ul style="list-style-type: none">• Sits face-to-face to the resident/patient (when possible), instead of standing over him/her• Maintains an open stance (does not cross arms or legs)• Observes nonverbal communication while communicating with a resident/patient.• Is alert, but relaxed and takes enough time, so that the resident/patient feels at ease• Keeps the communication natural and avoids sounding too anxious or eager• (If culturally acceptable), maintains eye contact, but does not stare• Indicates that he/she is paying attention by nodding and/or using appropriate facial gestures – and does not overdo this• Thinks before making responses• Does not pretend to listen, <u>but listens</u>• Attempts to understand what the resident/patient is saying• Observes nonverbal communication	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<p><i>Handout - Distribute Handout #2</i></p> <p><i>Overhead - Show Overhead #6</i></p> <p><u>Nonverbal Communication</u></p> <p>Defined - the exchange of information without using words.</p> <p>Expresses more of the true meaning of a message than what is actually being said in words.</p> <p>Includes paralanguage and body language.</p> <p><i>Overhead - Show Overhead #7</i></p> <p><u>Paralanguage</u></p> <ul style="list-style-type: none">• All vocal sounds (not words) made during a verbal exchange• Includes the quality of words, such as pitch, rate, and volume; and other associated sounds, such as whistles, mumbles, volume, and tone• May be appropriate.<ul style="list-style-type: none">- Examples of sounds, a surprised person may draw in a deep breath, and a person in pain may moan- Examples of word quality, an angry person may yell; an excited person may talk very fast in a lively manner.• May be inappropriate<ul style="list-style-type: none">- Example, a person who is obviously angry states, "No, I'm just fine."- Example, a person who is sitting calmly and smiling states, "I am in so much pain."	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<p><u>Body language</u></p> <ul style="list-style-type: none"> • Behaviors that involve body parts, movement, distance, and presentation of self to the world • Includes kinesics, proxemics, touch, and silence • Examples, eye contact/facial expressions, posture/gait, gestures, personal space, touch, and silence <p><u>Kinesics</u></p> <p>Defined – body language that includes eye contact, facial expressions, posture/gait, and gestures.</p> <p><i>Overhead - Show Overhead # 8</i></p> <p>Eye contact</p> <ul style="list-style-type: none"> • Defined – the act of one person directly looking into the eyes of another person • Its presence <ul style="list-style-type: none"> - Usually begins communication between two people - Suggests respect - Willingness to listen and to keep communication going - May relate to culture • Its absence <ul style="list-style-type: none"> - May indicate anxiety - May indicate weakness or low self-esteem - Usually done to avoid communication - May relate to culture 	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none"> • The eye itself <ul style="list-style-type: none"> - Person stares when angry - Eyes narrow when person is showing distrust - Eyes open wide when person is startled or afraid - A blank stare may indicate when person is daydreaming, tired, or bored <p><i>Overhead – Show Overhead #9</i></p> <p>Facial expression</p> <ul style="list-style-type: none"> • Most expressive part of the body • Various messages conveyed – joy, anger, sadness, fear, and distrust • Degree of variation ranges from extremely expressive to stone-faced attempts to mask expressions • Important for health care providers to control facial expressions <ul style="list-style-type: none"> - Reason – resident/patient can observe reactions by health care provider during procedures - Signs of rejection or disgust may impact resident/patient's self-image and recovery - Examples, grimacing during an abdominal dressing change or while cleaning a colostomy bag <p><i>Overhead – Show Overhead #10</i></p> <p>Posture/gait</p> <ul style="list-style-type: none"> • Defined – way a person holds the body while standing still (posture) and walking (gait) • People who are in good health or feel good about themselves hold their bodies in proper alignment and have a bouncy, determined walk 	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Reasons for improper alignment<ul style="list-style-type: none">- Depressed, sad or tired people are likely to slouch and shuffle when walking- People in pain may walk stiffly or crouch- People with recent abdominal surgery may walk slowly and slightly bent over <p><i>Overhead – Show Overhead #11</i></p> <p>Gestures</p> <ul style="list-style-type: none">• Defined – movement of the arms, legs, head, or body to express meaning• Examples, an angry person kicks a trashcan or excited person may wave his/her arms• Often used between two people speaking different languages and attempting to communicate <p><i>Overhead – Show Overhead #12</i></p> <p><u>Proxemics</u></p> <p>Defined – the use of space when communicating</p> <p>Four Proxemic Zones</p> <p><i>Overhead – Show Overhead #13</i></p> <ul style="list-style-type: none">• Intimate distance<ul style="list-style-type: none">- Distance is between 0 and 1.5 feet from another person	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none"> - Close physical contact - Examples, lovemaking, telling someone a secret, sharing confidential information <ul style="list-style-type: none"> • Personal distance <ul style="list-style-type: none"> - Distance is between 1.5 feet and 4 feet from another person - Examples, interviewing a person; nursing care that involves touch, such as checking vital signs, turning a resident/patient, private conversations; teaching someone a task <p><i>Overhead – Show Overhead #14</i></p> <ul style="list-style-type: none"> • Social distance <ul style="list-style-type: none"> - Distance is between 4 feet and 12 feet from another person - Conversational and basic social contact - Examples, group meetings, end of shift report, conversations that are not to be kept private • Public distance <ul style="list-style-type: none"> - Distance is 12 feet or more from another person - Impersonal contact - Examples, giving or hearing speeches, walking down the street <p><i>Overhead – Show Overhead #15</i></p> <p>Personal Space</p> <ul style="list-style-type: none"> • A private zone or “bubble” around our body that a 	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<p>person views as an extension of him/herself and belongs to him/her</p> <ul style="list-style-type: none"> • The comfort zone is the area just inside a person's personal space, that when entered by another person, does not cause distress for the person • Most Americans are comfortable being 2 to 3 feet from strangers <p><i>Overhead - Show Overhead #16</i></p> <ul style="list-style-type: none"> • Certain people are allowed and commonly enter a person's personal space for specific purposes • People tend to get uncomfortable if another person enters into their personal space <p><i>Overhead - Show Overhead #17</i></p> <ul style="list-style-type: none"> • Size of a person's personal space may increase (such as in an unfamiliar setting) or may decrease (such as in a crowded elevator) • When confined to bed, a resident/patient's personal space is the edges of the mattress • Size of a person's personal space is also cultural <p><i>Overhead - Show Overhead #18</i></p> <ul style="list-style-type: none"> • In America, most maintain similar distances based on relationship with the other person and the activity involved <p>Importance</p> <ul style="list-style-type: none"> • Determining the resident/patient's comfort zone is 	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<p>important because of the physical closeness needed to provide nursing care</p> <ul style="list-style-type: none"> • Health care provider should be aware of resident/patient nonverbal behavior indicating that health care provider is too close and is beyond his/her comfort zone <ul style="list-style-type: none"> - When standing, watch for signs of backward movements or actual backing up motion - When the resident/patient is lying in bed, watch for signs such as tucking the chin in, tensing of muscles • Approaches by Health Care Provider <ul style="list-style-type: none"> - Inform or explain to resident/patient what health care provider is going to do for them - Drape the resident/patient appropriately - If resident/patient displays signs that health care provider is too close, he/she should stop and slightly back off <p><i>Overhead - Show Overhead #19</i></p> <p><u>Touch</u></p> <p>Defined - to cause a part of the body, usually a hand, to come in contact with another object or person</p> <p>Nursing is hands-on profession, and therefore, requires health care providers frequent personal contact with residents/patients</p> <p>A resident/patient's personal feelings regarding touch range from "reaching out for the health care provider's hand" to recoiling or "drawing back" from the touch of another person</p>	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<p>In health care, touch is either task-oriented or affective</p> <p>Task-oriented touch – personal contact that is needed to perform nursing tasks</p> <p><i>Overhead – Show Overhead #20</i></p> <p>Affective touch – personal contact that is used to show concern or affection</p> <ul style="list-style-type: none">• One of the most effective nonverbal ways to express feelings, such as caring, comfort, love, anger, affection, and security• Used when a resident/patient is lonesome, uncomfortable, near death, anxious, frightened, confused, in a coma, and visually impaired• Should be careful about its use• Means different things to different people based on age, sex, race, culture, family, class• Often it is a good idea to ask permission to touch a new resident/patient (“May I give you a hug?”) until both of you feel comfortable with each other <p><i>Overhead – Show Overhead #21</i></p> <p>Silence</p> <p>Defined – the act of remaining quiet</p> <p>Meanings</p> <ul style="list-style-type: none">• Resident/patient may be comfortable and content with the present relationship with the health care provider	

Objective 3: Outline the importance of understanding nonverbal communication while communicating with a resident/patient.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Resident/patient may be trying to cope without help from the health care provider• Resident/patient may be thinking or pondering something that has been said or done• Resident/patient may be afraid and is using silence to escape from threat <p>The health care provider's reaction to silence</p> <ul style="list-style-type: none">• May feel uncomfortable and begin talking too soon• May talk, just for the sake of talking and filling in gaps• May use the time to observe the resident/patient or think about what has been said or done	

Objective 4: Contrast therapeutic and non-therapeutic communication techniques.

<u>Content</u>	<u>Notes</u>
<p><i>Handout - Distribute Handout #3</i></p> <p><i>Overhead - Show Overhead #22</i></p> <p><u>Therapeutic Communication</u></p> <p>Defined - the art of using words and gestures to promote a person's physical and emotional well-being</p> <p>Appropriate setting to promote therapeutic communication</p> <ul style="list-style-type: none">• Comfortable environment - suitable furniture; proper lighting; moderate temperature; relaxed, unhurried pace• Privacy - provide privacy so communications will not be overheard by others, draw privacy curtains around bed, choose a corner in the activity room away from others <p><u>Therapeutic Communication Techniques</u></p> <p>Broad openings</p> <ul style="list-style-type: none">• Use - relieves tension• Example - <i>"Nice weather we are having."</i> <p>Giving information</p> <ul style="list-style-type: none">• Use - provides facts• Example - <i>"Your breakfast will be a little late today."</i> <p>Direct questioning</p> <ul style="list-style-type: none">• Use - seeking information• Example - <i>"Do you have a clean gown?"</i>	

Objective 4: Contrast therapeutic and non-therapeutic communication techniques.

<u>Content</u>	<u>Notes</u>
<p>Open-ended questioning</p> <ul style="list-style-type: none">• Use - encourages client to elaborate, prevents yes/no answers• Example - <i>"How are you feeling today?"</i> <p>Reflecting</p> <ul style="list-style-type: none">• Use - shows interest, repeats what is heard, encourages resident/ patient to expand, do not overuse• Example - "I feel sick." <i>"You feel sick?"</i> <p>Paraphrasing</p> <ul style="list-style-type: none">• Use - restates what resident/patient has said and shows interest• Example - "Every time I smell food, I feel like I will throw up." <i>"Smelling food makes you nauseated, but you don't actually throw up."</i> <p>Structuring</p> <ul style="list-style-type: none">• Use - states a purpose and sets limits• Example - <i>"I have 10 minutes. If you would like, I'll take a walk with you."</i> <p>Giving general leads</p> <ul style="list-style-type: none">• Use - encourages resident/patient to continue• Example - <i>"Uh huh." Or "Go on."</i> <p>Sharing perceptions</p> <ul style="list-style-type: none">• Use - shows empathy for how resident/patient is feeling• Example - <i>"You seem happy today."</i> <p>Clarifying</p> <ul style="list-style-type: none">• Use - avoids misunderstanding	

Objective 4: Contrast therapeutic and non-therapeutic communication techniques.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Example – <i>“I’m afraid I don’t understand what you are saying.”</i> <p>Validating</p> <ul style="list-style-type: none">• Use – verifies what is heard• Example – <i>“In report, we heard you were nauseated. How are you feeling now?”</i> <p>Summarizing</p> <ul style="list-style-type: none">• Use – reviews information that has been discussed• Example – <i>“You would like a clean gown and water for your plants?”</i> <p><i>Overhead – Show Overhead #23</i></p> <p><u>Nontherapeutic Communication Techniques</u></p> <p>Giving false reassurance</p> <ul style="list-style-type: none">• What it does - makes the resident/patient feel less important• Example – <i>“Don’t worry, you’ll be OK.”</i>• Better – <i>“Tell me about what’s bothering you.”</i> <p>Using cliches</p> <ul style="list-style-type: none">• What it does – gives worthless advice• Example – <i>“Cheer up. Tomorrow will be a better day.”</i>• Better – <i>“It must be tough for you right now.”</i> <p>Giving approval</p> <ul style="list-style-type: none">• What it does – sets a standard that resident/patient may not be able to live up to. Implies that if he/she does not do as well, health care provider will be disappointed.	

Objective 4: Contrast therapeutic and non-therapeutic communication techniques.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Example – “I’m glad to see you walk down the hall everyday.”• Better – <i>“I’ve noticed that you have been walking down the hall regularly.”</i> <p>Agreeing</p> <ul style="list-style-type: none">• What it does – does not allow the resident/patient to change his/her mind later on• Example – “You’re right about the importance of a low fat diet.”• Better – <i>“Eating a low fat diet is one way to lose weight. Have you considered other types of diets?”</i> <p>Disagreeing</p> <ul style="list-style-type: none">• What it does – makes the resident/patient feel foolish or less of a person• Example – “That’s not true. Who in the world told you that?”• Better – <i>“Let me go check on that for you.”</i> <p>Demanding an explanation</p> <ul style="list-style-type: none">• What it does – makes the resident/patient defensive.• Example - Why didn't you go to resident's council this morning. (Never ask him/her “why?” questions)• Better – <i>“I missed seeing you at resident's council today.”</i> <p>Giving advice</p> <ul style="list-style-type: none">• What it does – discourages own problem solving.• Example – “If I were you, I’d change doctors.” (Includes any statements that begin, “If I were you,”)• Better – <i>“You seem upset about what your doctor said today.”</i>	

Objective 4: Contrast therapeutic and non-therapeutic communication techniques.

<u>Content</u>	<u>Notes</u>
<p>Defending</p> <ul style="list-style-type: none">• What it does – means that if resident/patient disagrees, may be consequences• Example – “Mary is my friend. She wouldn’t have let your call bell keep ringing.”• Better – <i>“Gee, I’m sorry you had to wait so long.”</i> <p>Belittling</p> <ul style="list-style-type: none">• What it does – does not take what the resident/patient is saying into consideration• Example – “Oh anybody can learn how to walk with a cane. It’s easy.”• Better – <i>“You’re finding it hard to walk with a cane?”</i> <p>Patronizing</p> <ul style="list-style-type: none">• What it does – is very condescending towards the patient/resident• Example – “Are we ready for <i>our</i> bath yet?”• Better – <i>“Would you like your bath now or later?”</i> <p>Changing the subject</p> <ul style="list-style-type: none">• What it does – health care provider tries to change the subject to a “safer” topic• Example – “I’m so scared I’ve got cancer.” “Nice weather we’re having.”• Better – <i>“It is a serious disease. What makes you think you have cancer?”</i> <p>Using leading questions</p> <ul style="list-style-type: none">• What it does – suggests a response that the health care provider wants to hear• Example – “You aren’t going to eat those potato chips, are you?”• Better – <i>“I see you’ve got a bag of potato chips.”</i>	

Objective 4: Contrast therapeutic and non-therapeutic communication techniques.

<u>Content</u>	<u>Notes</u>
<i>Written Activity - Distribute Written Activity #1 to participants.</i> <i>Discussion - Upon completion of Written Activity #1, discuss answers with participants.</i>	

WRITTEN ACTIVITY

For

***ADVANCED
COMMUNICATION***

Part One

**Advanced Communication Skills
Part One Written Activity #1**

Read the following statements that were made by Hannah Health Care Provider. If the statement is therapeutic and appropriate, place a "T" on the line. If the statement is non-therapeutic, place an "N" on the line. You may use your notes. If you determine, the statement is non-therapeutic, tell why in the blank space. You have 15 minutes to complete this activity.

_____ 1. "Why did you say such a thing?"

_____ 2. "This rain is going to help the crops."

_____ 3. "In my opinion, this hospital is much better than County General."

_____ 4. "I am so very glad you ate all your breakfast."

_____ 5. "Are we ready to go for our walk?"

_____ 6. "Your lunch will be delayed because of lab work."

_____ 7. "Do you prefer the blue robe or the green one?"

_____ 8. "Oh, anyone can learn how to use a walker."

_____ 9. "I have 10 minutes. Would you like for me to read a Bible story to you now?"

_____ 10. "Uh huh."

_____ 11. "I would never say such a thing about your choice in clothes."

_____ 12. "You seem happy today."

_____ 13. "Don't worry. Everything will be all right. I promise."

_____ 14. "Cheer up. Today is a new day."

_____ 15. "You are so very right about her abilities as a nurse. She is clueless."

_____ 16. "Why didn't you go to crafts this morning?"

_____ 17. "Why do you think you have a hernia?"

_____ 18. "Surely you are not going to eat that whole steak, are you?"

_____ 19. "In report, we heard you had a headache. Is it better now?"

_____ 20. "I feel sick." "You feel sick?"

Advanced Communication Skills
Part One Written Activity #1
Answer Key

Read the following statements that were made by Hannah Health Care Provider. If the statement is therapeutic and appropriate, place a "T" on the line. If the statement is non-therapeutic, place an "N" on the line. You may use your notes. If you determine, the statement is non-therapeutic, tell why in the blank space. You have 15 minutes to complete this activity.

- N 1. "Why did you say such a thing"? [Demanding an explanation]
- T 2. "This rain is going to help the crops." [Broad opening]
- N 3. "In my opinion, this hospital is much better than County General."
[Giving advice]
- N 4. "I am so very glad you ate all your breakfast." [Giving approval]
- N 5. "Are we ready to go for our walk?" [Patronizing]
- T 6. "Your lunch will be delayed because of lab work." [Giving information]
- T 7. "Do you prefer the blue robe or the green one?" [Direct questioning]
- N 8. "Oh, anyone can learn how to use a walker." [Belittling]
- T 9. "I have 10 minutes. Would you like for me to read a Bible story to you now?" [Structuring]
- T 10. "Uh huh." [Giving general leads]
- N 11. "I would never say such a thing about your choice in clothes."
[Defending]
- T 12. "You seem happy today." [Sharing perceptions]

- ___N___ 13. "Don't worry. Everything will be all right. I promise." [Giving false reassurances]
- ___N___ 14. "Cheer up. Today is a new day." [Using a cliché]
- ___N___ 15. "You are so very right about her abilities as a nurse. She is clueless." [Agreeing]
- ___N___ 16. "Why didn't you go to crafts this morning?" [Demanding an explanation]
- ___N___ 17. "Why do you think you have a hernia?" [Demanding an explanation]
- ___N___ 18. "Surely you are not going to eat that whole steak, are you?" [Using leading questions]
- ___T___ 19. "In report, we heard you had a headache. Is it better now?" [Validating]
- ___T___ 20. "I feel sick." "You feel sick?" [Reflecting]

HANDOUTS

For

**ADVANCED
COMMUNICATION**

Part One

Advanced Communication Handout #1

Communication Process

Communication – a continuous, simultaneous, and reciprocal exchange or sharing of information involving at least two people

People who communicate receive and send messages through verbal and nonverbal means.

Elements of Communication

Sender - person that prepares and sends a message to a receiver

Receiver – person that receives, translates, and makes a decision about a message sent by the sender

Message – actual information sent by the sender to the receiver

Sensory channel – the way that a message is being sent and may target one or more of the receiver's senses (vision, hearing, touching)

Feedback – verbal and nonverbal evidence that the receiver has received and understood the message sent

Context – the conditions or location in which the communication occurs

Messages sent and messages received are influenced by knowledge, past experiences, feelings, position of the individual in the relationship

Listening

The process of attending to and becoming involved in what is said by another person or persons. Involves not only hearing what is said, but also involves interpreting what is heard

A Good Listener

Sits face-to-face to the resident/patient (when possible), instead of standing over him/her

Maintains an open stance (does not cross arms or legs)

Observes nonverbal communication while communicating with a resident/patient

Is alert, but relaxed and takes enough time, so that the resident/patient feels at ease

Keeps the communication natural and avoids sounding too anxious or eager

(If culturally acceptable), maintains eye contact, but does not stare

Indicates that he/she is paying attention by nodding and/or using appropriate facial gestures – and does not overdo this

Thinks before making responses

Does not pretend to listen, **but listens**

Attempts to understand what the resident/patient is saying

Observes nonverbal communication

Advanced Communication Handout #2

Nonverbal Communication

The exchange of information without using words

Expresses more of the true meaning of a message than what is actually being said in words

Includes paralanguage and body language

Paralanguage

All vocal sounds (not words) made during a verbal exchange

Includes the quality of words, such as pitch, rate, and volume; and other associated sounds, such as whistles, mumbles, volume, and tone

May be appropriate or inappropriate.

Body language

Behaviors that involve body parts, movement, distance, and presentation of self to the world

Includes kinesics, proxemics, touch, and silence

Kinesics

Body language that includes eye contact, facial expressions, posture/gait, and gestures.

Eye contact - the act of one person directly looking into the eyes of another person

Facial expression - most expressive part of the body

Posture/gait - way a person holds the body while standing still (posture) and walking (gait)

Gestures - movement of the arms, legs, head, or body to express meaning

Proxemics - the use of space when communicating

- Intimate distance
 - Distance is between 0 and 1.5 feet from another person
 - Close physical contact
 - Examples?
- Personal distance
 - Distance is between 1.5 feet and 4 feet from another person
 - Examples?
- Social distance
 - Distance is between 4 feet and 12 feet from another person
 - Conversational and basic social contact
 - Examples?
- Public distance
 - Distance is 12 feet or more from another person
 - Impersonal contact
 - Examples?

Most Americans are comfortable being 2 to 3 feet from strangers

Personal space - private zone or “bubble” around our body that a person views as an extension of his/herself and belongs to him/her

Comfort zone - the area just inside a person's personal space, that when entered by another person, does not cause distress for the person

Importance of proxemics:

- Determining the resident/patient's comfort zone is important because of the physical closeness needed to provide nursing care
- Health care provider should be aware of resident/patient nonverbal behavior indicating that health care provider is too close and is beyond his/her comfort zone
 - When standing, watch for signs of backward movements or actual backing up motion
 - When the resident/patient is lying in bed, watch for signs such as tucking the chin in, tensing of muscles
- Approaches by Health Care Provider
 - Inform or explain to resident/patient what health care provider is going to do for them
 - Drape the resident/patient appropriately
 - If resident/patient displays signs that health care provider is too close, he/she should stop and slightly back off

Touch – to cause a part of the body, usually a hand, to come in contact with another object or person

Task-oriented touch – personal contact that is needed to perform nursing tasks

Affective touch – personal contact that is used to show concern or affection

Silence - the act of remaining quiet

Advanced Communication Handout #3

Therapeutic Communication

Defined – the art of using words and gestures to promote a person's physical and emotional well-being

Appropriate setting to promote therapeutic communication

- Comfortable environment – suitable furniture; proper lighting; moderate temperature; relaxed, unhurried pace
- Privacy – provide privacy so communications will not be overheard by others, draw privacy curtains around bed, choose a corner in the activity room away from others

Therapeutic Communication Techniques

Broad openings

- Use – relieves tension
- Example – *"Nice weather we are having."*

Giving information

- Use – provides facts
- Example – *"Your breakfast will be a little late today."*

Direct questioning

- Use – seeking information
- Example – *"Do you have a clean gown?"*

Open-ended questioning

- Use – encourages client to elaborate, prevents yes/no answers
- Example – *"How are you feeling today?"*

Reflecting

- Use – shows interest, repeats what is heard, encourages resident/patient to expand, do not overuse
- Example – “I feel sick.” *“You feel sick?”*

Paraphrasing

- Use – restates what resident/patient has said and shows interest
- Example – “Every time I smell food, I feel like I will throw up.” *“Smelling food makes you nauseated, but you don’t actually throw up.”*

Structuring

- Use – states a purpose and sets limits
- Example – *“I have 10 minutes. If you would like, I’ll take a walk with you.”*

Giving general leads

- Use – encourages resident/patient to continue
- Example – *“Uh huh.” Or “Go on.”*

Sharing perceptions

- Use – shows empathy for how resident/patient is feeling
- Example – *“You seem happy today.”*

Clarifying

- Use – avoids misunderstanding
- Example – *“I’m afraid I don’t understand what you are saying.”*

Validating

- Use – verifies what is heard
- Example – *“In report, we heard you were nauseated. How are you feeling now?”*

Summarizing

- Use – reviews information that has been discussed
- Example – *“You would like a clean gown and water for your plants?”*

Nontherapeutic Communication Techniques

Giving false reassurance

- What it does - makes the resident/patient feel less important
- Example – *“Don’t worry, you’ll be OK.”*
- Better Response?

Using cliches

- What it does – gives worthless advice
- Example – *“Cheer up. Tomorrow will be a better day.”*
- Better Response?

Giving approval

- What it does – sets a standard that resident/patient may not be able to live up to. ‘Implies that if he/she does not do as well, health care provider will be disappointed
- Example – *“I’m glad to see you walk down the hall everyday.”*
- Better Response?

Agreeing

- What it does – does not allow the resident/patient to change his/her mind later on
- Example – *“You’re right about the importance of a low fat diet.”*
- Better Response?

Disagreeing

- What it does – makes the resident/patient feel foolish or less of a person
- Example – *“That’s not true. Who in the world told you that?”*
- Better response?

Demanding an explanation

- What it does – makes the resident/patient defensive.
- Example – *“Why didn’t you go to resident’s council this morning.”* (Never ask him/her “why?” questions)
- Better response?

Giving advice

- What it does – discourages own problem solving.
- Example – *“If I were you, I’d change doctors.”* (Includes any statements that begin, “If I were you,”)
- Better response?

Defending

- What it does – means that if resident/patient disagrees, may be consequences
- Example – *“Mary is my friend. She wouldn’t have let your call bell keep ringing.”*
- Better response?

Belittling

- What it does – does not take what the resident/patient is saying into consideration
- Example – *“Oh, anybody can learn how to walk with a cane. It’s easy.”*
- Better response?

Patronizing

- What it does – is very condescending towards the patient/resident
- Example – *“Are we ready for our bath yet?”*
- Better response?

Changing the subject

- What it does – health care provider tries to change the subject to a “safer” topic
- Example – *“I ‘m so scared I ‘ve got cancer.” “Nice weather we’re having.”*
- *Better response?*

Using leading questions

- What it does – suggests a response that the health care provider wants to hear
- Example – *“You aren’t going to eat those potato chips, are you?”*
- Better response?

OVERHEADS

For

***ADVANCED
COMMUNICATION***

Part One

Communication Process

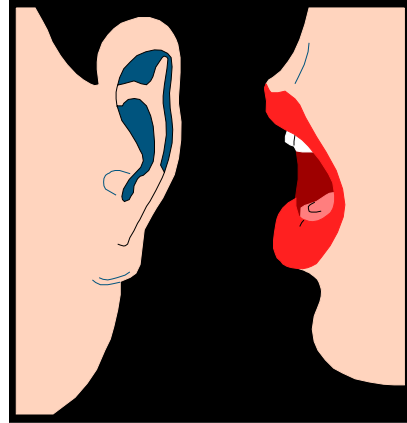
Communication is:

- **An exchange/sharing of info**
- **Involves at least 2 people**
- **Is continuous,
simultaneous,
& reciprocal.**

**People who communicate
receive and send
messages through
verbal/nonverbal means**

Elements of Communication

- **Sender** – person that prepares/sends a message to a receiver
- **Receiver** – person that receives/ translates/ makes a decision about a message sent by the sender
- **Message** – actual information sent
- **Sensory channel** – way that a message is being sent & may target one or more of the receiver's senses
- **Feedback** – verbal/nonverbal evidence that the receiver has received/understood the message
- **Context** – the conditions or location in which the communication occurs



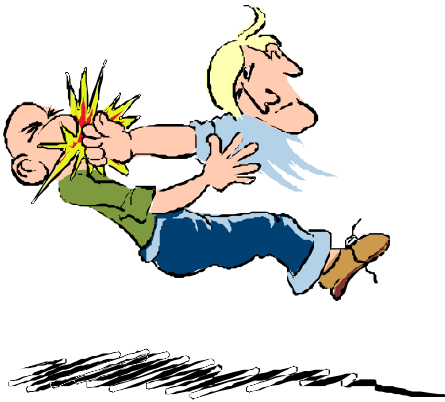
Elements of Communication

Messages sent/received
Are influenced by:

Knowledge



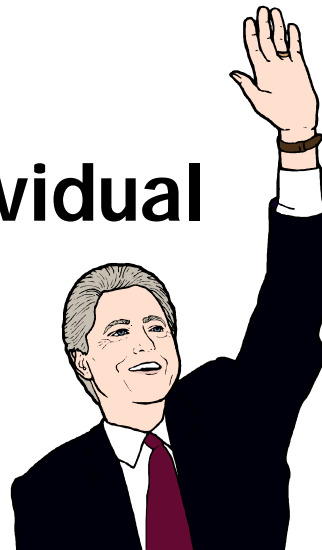
Past
experiences



Feelings



Position of individual
in the
relationship





Listening



**Process of
attending to
& becoming involved in
what is said by another
person/persons.**



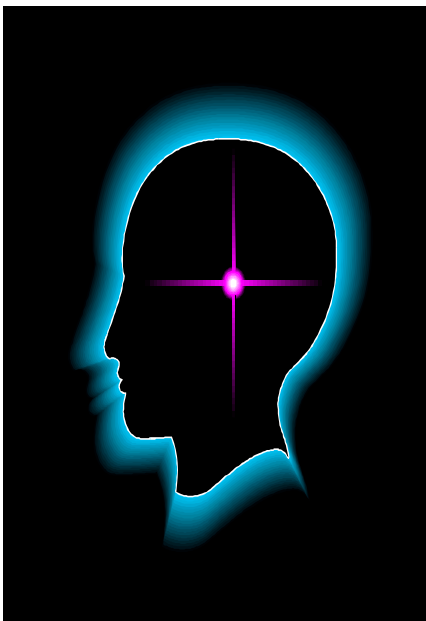
**"Involves more than just
hearing what is said"**

**but also involves
interpreting what
is heard**



A Good Listener

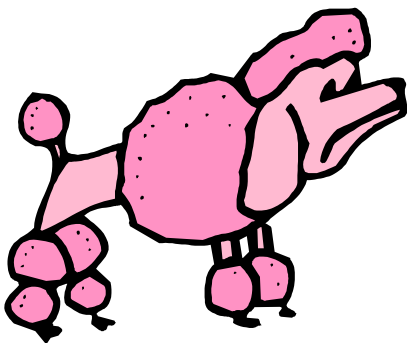
- Sits face-to-face,
- Maintains open stance
 - Observes nonverbal communication
 - Is alert, relaxed, takes time
 - Keeps communication natural
 - Maintains eye contact
 - Indicates he/she is paying attention
- Thinks before responding
- Really listens
- Attempts to listen



Nonverbal Communication

- The exchange of information without using words
- Expresses more of the true meaning of a message than what is actually being said in words
- Includes:

Paralanguage



Body language

Paralanguage

- Vocal sounds (not words) made
- Includes:

Quality of Words &



I SAID
NO!!!!

Zzzzzzz



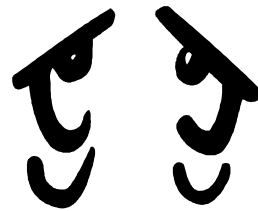
Associated
Sounds

- Appropriate or inappropriate?

Body Language - Kinesics

Eye contact - the act of one person directly looking into the eyes of another person

- Presence or



Absence?

The eye may:

Narrow



Stare



Open Wide



Blank Stare



Body Language - Kinesics

Facial expression - face is most expressive body part

- Degree of variation
- Various messages conveyed

Joy



Anger



Sadness



Importance in
Health Care?

Body Language – Kinesics



Posture – way a person holds the body while standing

Gait – way a person holds the body while walking

People in good health/feel good about themselves:

- **Have bodies in proper alignment**
- **Have a bouncy, determined walk**

Reasons for improper alignment?

Body Language – Kinesics

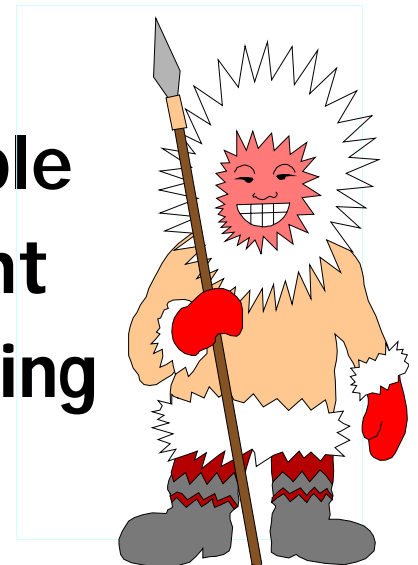


Gesture – movement of the arms, legs, head, or body to express meaning

Examples?

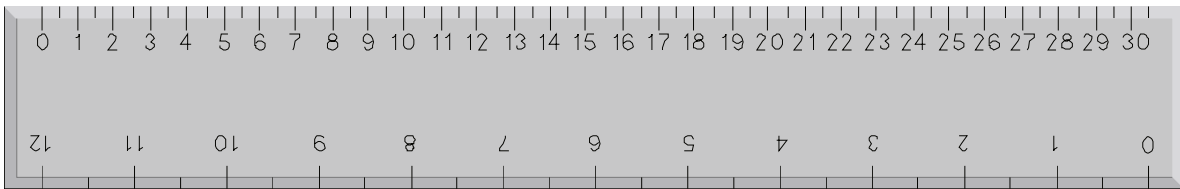


Often used between two people speaking different languages attempting to communicate



Body Language – Proxemics

**Is the use of
space when
communicating**



Four Proxemic Zones

Intimate distance

Personal distance

Social distance

Public distance

Body Language – Proxemics

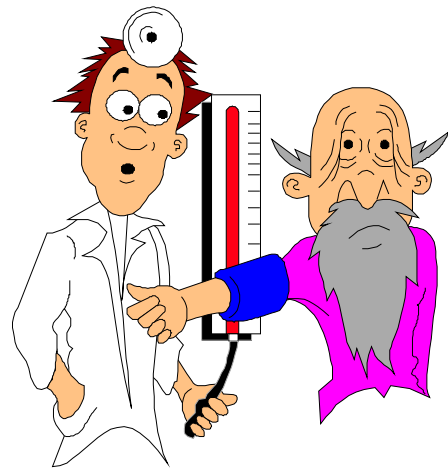
Intimate distance

- Between 0 and 1.5 feet from another person
- Close physical contact
- Examples?



Personal distance

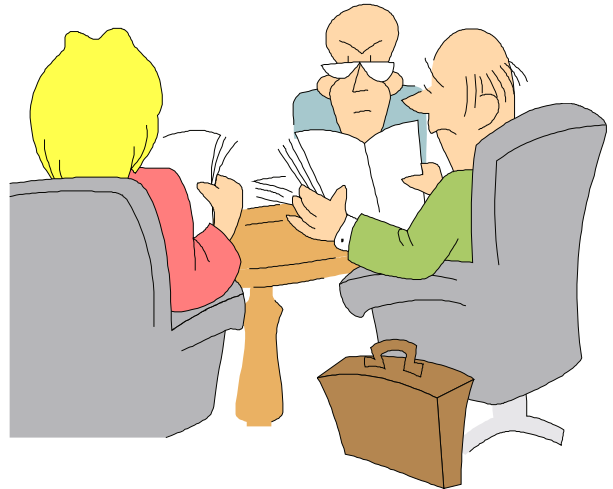
- Between 1.5 and 4 feet from another person
- Examples?



Body Language – Proxemics

Social distance

- Between 4 & 12 feet from another person
- Conversational & basic social contact
- Examples?



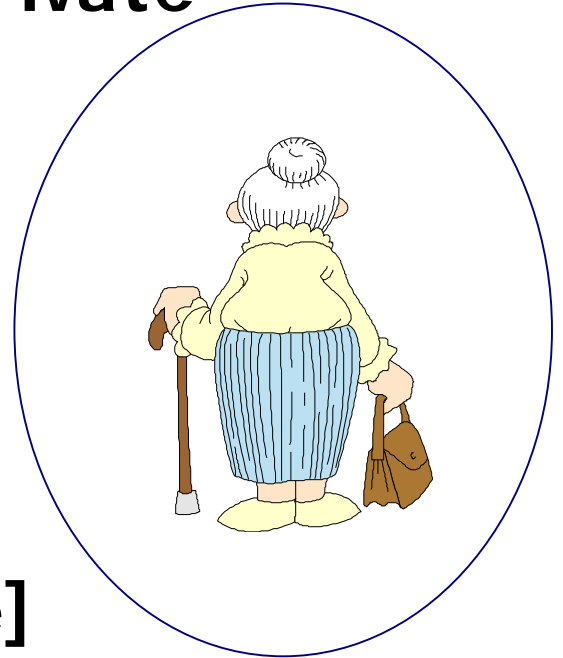
Public distance

- 12 feet or more from another person
- Impersonal
- Examples?



Body Language – Proxemics

Personal Space is a private zone/“bubble” around our body that a person views as a part of self & belongs to him/her [do inside of a bubble]



Comfort zone is the area just inside a person's personal space, that when entered by another person, does not cause distress for the person

Body Language – Proxemics

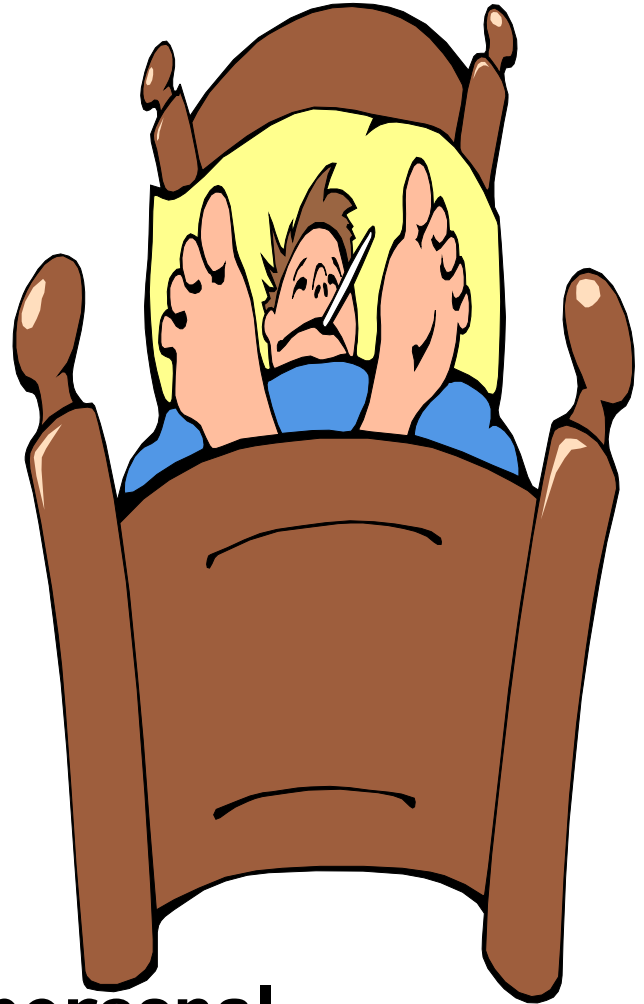
Personal space

- **People tend to get uncomfortable if another person enters into their personal space**
- **Certain people are allowed & commonly enter a person's personal space for specific purposes**

Body Language - Proxemics

Personal space

- Size of a person's personal space may increase or decrease
- When confined to bed, a person's personal space is the edges of the mattress
- Size of a person's personal space is also cultural



Body Language – Proxemics

How close is too close?

In America, most people maintain similar distances based on relationship with the other person and the activity involved.

How do we know when we are too close to someone?

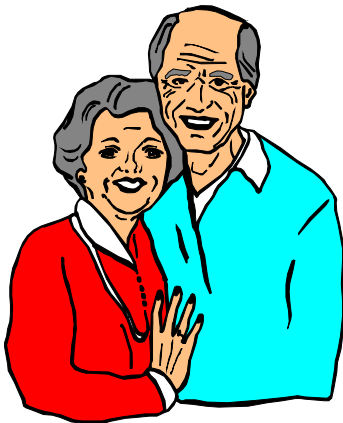
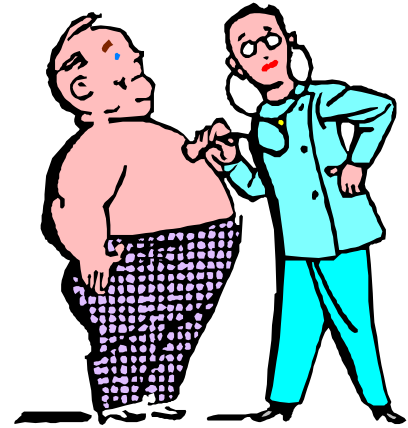
- When standing, watch for signs of backward movements
- When bed, watch for signs such as tucking the chin in/tensing muscles

Why is understanding personal space & comfort zone important to the health care provider?

Body Language - Touch

To touch is to cause a part of the body (usually a hand) to come in contact with another object or person

In health care, touch is either:
task-oriented -
personal contact
that is needed
to perform nursing
tasks or



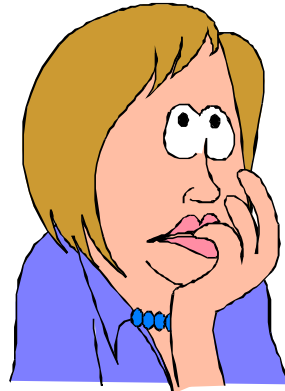
- affective - personal contact that is used to show concern or affection

Body Language - Touch

Affective Touch is one of the most effective nonverbal ways to express feelings, such as caring, comfort, love, anger, affection, and security.

Used when a resident/patient is:

lonesome, near death,
uncomfortable,
anxious, frightened,
confused, in a coma,
or visually impaired



Why should health care providers be careful about the use of touch?

Body Language - Silence

Silence is the act of remaining quiet

If used by the resident/patient,

- He/she may be comfortable & content
- He/she may be trying to cope without help
- He/she may be thinking or pondering something that has been said or done
- He/she may be afraid & is using silence to escape from threat

How? do you react to silence?
might the health care
provider react to silence?

Therapeutic Communication

Defined

Is the art of using words and gestures to promote a person's physical and emotional well-being

Techniques



Broad openings
Giving information
Direct questioning
Open-ended questioning
Reflecting
Paraphrasing
Structuring
Giving general leads
Sharing perceptions
Clarifying
Validating
Summarizing

Non-therapeutic Communication

Defined

Is the act of using words and gestures that do not promote a person's physical and emotional well-being

Techniques



Giving false reassurance

Using cliches

Giving approval

Agreeing

Disagreeing

Demanding an explanation

Giving advice

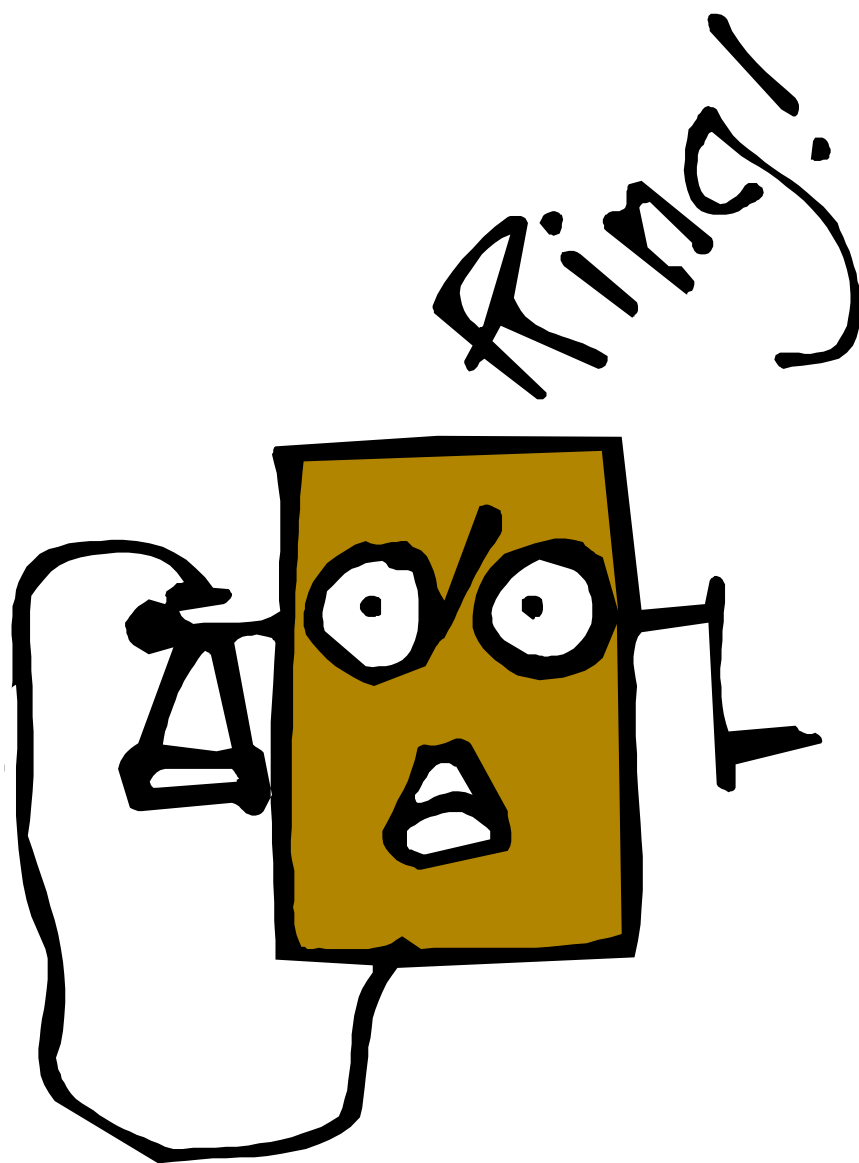
Defending

Belittling

Patronizing

Changing the subject

Advanced Communication Skills Curriculum Module



Part Two

Objective 5: Select appropriate communication techniques in unique health care situations: caring for an anxious resident/patient.

<u>Content</u>	<u>Notes</u>
<i>Handout - Distribute Handout #1</i>	
<i>Overhead - Show Overhead #1</i>	
Anxiety - a feeling of uneasiness or dread that occurs as a response to a perceived threat	
Possible causes - being admitted to a nursing home or hospital and all that it entails	
<i>Overhead - Show Overhead #2</i>	
How does the health care provider know when a resident/patient is anxious?	
<ul style="list-style-type: none">• Excessive perspiration including sweaty hands• Wringing of the hands, tremors• Repetitious questioning, continually forgetting things, short attention span, difficulty in concentrating, restlessness• Difficulty in sleeping• Rapid pulse, racing heart• Dilated pupils• Diarrhea, urinary frequency,• Indigestion• May be tearful, easily angered, have frequent complaints, be overly happy, or irritable• May frequently use call bell	
<i>Overhead - Show Overhead #3</i>	
Everyone has periods of anxiety. The degree of anxiety determines whether it is positive or negative.	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for an anxious resident/patient.

<u>Content</u>	<u>Notes</u>
<p>Approaches</p> <p>Be understanding of resident/patient's feelings</p> <ul style="list-style-type: none">• Lets him/her know health care provider recognizes that he/she is anxious• Example - "You must be very uncomfortable now. As you get used to the facility, you will feel more at ease." <p>When approaching the resident/patient, speak slowly, briefly, and concretely.</p> <ul style="list-style-type: none">• Will increase the likelihood that resident/patient will understand what is said• Example - "Here is your lunch. Let me open your milk." <p>Use measures to increase the resident/patient's comfort</p> <ul style="list-style-type: none">• Provide comforting measures - warm milk, warm bath, soft lights, back rubs; restrict caffeine intake <p>Tell the resident/patient you are concerned about his/her feelings.</p> <ul style="list-style-type: none">• Acknowledge difficult time resident/patient is having• Example - "It must be very difficult for you to be here, when your mind is on so many things."• Example of what not to say - "In a few hours you'll be fine." "Everyone gets better in this hospital/nursing home."	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for an anxious resident/patient.

<u>Content</u>	<u>Notes</u>
<p>Encourage the resident/patient to verbalize his feelings about what he/she remembers that happened before he/she became anxious.</p> <p><i>Overhead - Show Overhead #4.</i></p> <p>Do not use meaningless phrases</p> <ul style="list-style-type: none">• Makes the resident/patient feel less important• Example of what not to say - "Just relax." "Don't be nervous." "Just pull yourself together." <p>Don't offer suggestions as to the possible causes of the residents/patient's anxiety</p> <ul style="list-style-type: none">• May increase anxiety because the resident/patient is focusing on the cause• Example of what not to say - "Maybe if the lab would hurry up and do your lab work, you wouldn't be so anxious." <p>Do not make demands on the resident/patient when anxiety level is high</p> <ul style="list-style-type: none">• More stress on the resident will increase anxiety• Example of what not to say - "I know you are really upset now, but the kitchen needs your menu filled out right now."	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for an anxious resident/patient.

<u>Content</u>	<u>Notes</u>
<p>Do not try to reassure the resident/patient with empty explanations</p> <ul style="list-style-type: none">• Makes the resident/patient feel less important• Example of what not to say "Anyone would be anxious if they were married to your husband." "I'd be anxious too if I thought I had cancer." <p>Do not dwell about what the resident/patient is doing to relieve tension</p> <ul style="list-style-type: none">• resident/patient may be using call bell frequently, walking to the nurses station frequently• Examples of what not to say - " You are acting like a 3-year old." "Now, Mrs. Smith, I expected better behavior from you." <p>Do not become defensive when the resident/patient complains</p> <ul style="list-style-type: none">• May complain about everything and anything that health care provider does• Encourage resident/patient to identify what events preceded his/her anxiety• Example of what not to say - "It's not my fault that the kitchen is 2 minutes late bringing your lunch." "Give me a break. I was just in here for 20 minutes." AND... <p>Do not be surprised if logic is useless</p> <p>Do not expect the resident/patient to change his/her behavior immediately.</p>	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a depressed resident/patient.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #5.</i></p> <p>Reactive depression</p> <ul style="list-style-type: none"> • Defined - self-limiting depressed state that lessens or disappears when circumstances change or there is help from supportive others • Possible causes – death of a loved one, loss of a body part, diagnosis of an incurable disease <p><i>Overhead – Show Overhead #6.</i></p> <p>How does the health care provider know when a resident/patient has reactive depression?</p> <ul style="list-style-type: none"> • Decreased interest in surroundings, boredom • Tendency to continually talk or ponder the loss • May feel helpless • May cry, weep, scream, wail, or whine <p><i>Overhead – Show Overhead #7.</i></p> <p>Major Depression</p> <ul style="list-style-type: none"> • Defined – a sad mood for which there is no obvious relationship to situational events • Possible causes - shortage of certain chemicals in the brain, neglect or rejection as a baby, learned feelings of helplessness, continual exposure to discrimination, distorted or false view of self <p><i>Overhead – Show Overhead #8.</i></p>	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a depressed resident/patient.

<u>Content</u>	<u>Notes</u>
<p>How does the health care provider know when a resident/patient has major depression?</p> <ul style="list-style-type: none"> • Sad mood • Appetite change – increased or decreased • Disturbed sleep – too much or too little • Inability to concentrate • Marked decrease in pleasure • Apathy • Guilty feelings • Energy changes – restlessness or inactivity • Suicidal thoughts <p><i>Overhead – Show Overhead #9.</i></p> <p>Approaches</p> <p>Make initial contact with the resident/patient and share perceptions</p> <ul style="list-style-type: none"> • Shows caring behavior • Example - “You seem sad today. Maybe it would help if we talked about what’s troubling you.” <p>Tell the resident/patient that you care about and accept his/her feelings</p> <ul style="list-style-type: none"> • Shows caring behavior • Example - “Sometimes when something like this happens, people often feel helpless before they have a chance to think it through.” 	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a depressed resident/patient.

<u>Content</u>	<u>Notes</u>
<p>Let the resident/patient know that you feel he/she is worthy</p> <ul style="list-style-type: none"> • Do not overdo the flattery • Example – “I noticed how you helped Mrs. Smith read her book today.” <p>Show the resident/patient you care about him/her</p> <ul style="list-style-type: none"> • Sit with resident/patient, accept silences, tolerate tears <p>Pay attention to the resident/patient’s personal hygiene</p> <ul style="list-style-type: none"> • Offer assistance and direction • Do not criticize • Example – “I noticed that you have not brushed your hair today. May I help you brush it?” <p>Plan activities according to his/her degree of depression</p> <ul style="list-style-type: none"> • Tasks should be simple, should not require concentration • Example – “The activity coordinator is having a low impact exercise class in the activity room in 20 minutes. Would you like to walk down there with me?” <p>Resident/Patient Statements & Responses</p> <p>What can the healthcare provider say to a resident/patient that is crying?</p>	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a depressed resident/patient.

<u>Content</u>	<u>Notes</u>
<p>"I know this is a difficult time for you. Crying sometimes helps when dealing with these types of situations."</p> <p>What can the health care provider say to the resident/patient that requests something that he/she can not do at the moment?</p> <p>"I can not walk in the hall with you now, but I will be free to do so in an hour."</p> <p>What do you do if the resident/patient threatens suicide?</p> <p>I mmediately report statements to the supervisor.</p>	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a resident/patient with delirium.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #10.</i></p> <p>Delirium – a sudden, temporary state of confusion</p> <p>Causes – high fever, head trauma, brain tumor, certain medications, unfamiliar surroundings, illness, sundown</p> <p>How does the health care provider know when a resident/patient is delirious?</p> <p>Resident/patient is not oriented to person, place, time</p> <p><i>Overhead – Show Overhead #11.</i></p> <p>Approach</p> <p>Orient the resident/patient to his/her surroundings using verbal reminders, clocks, watches, calendar, newspaper</p> <ul style="list-style-type: none">• Example, “Hello, Mr. Smith. I am your nurse aide, Nancy Smith. You are in the Baylor Hospital. It is Thursday, June 15, 2000.” <p>Speak calmly and use simple words and statements Example, “Hello, Mr. Smith, It is time for breakfast. I will set up your tray for you.”</p> <p>Place familiar objects near the resident/patient</p> <p>Use frequent face-to-face contact when communicating</p> <p>May try touch, a hug, or a backrub (when appropriate)</p> <p>Allow resident/patient plenty of time to respond.</p>	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a hostile resident/patient.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #12.</i></p> <p>Hostile – the act of feeling or showing hatred or malice towards someone or something</p> <p>Causes – resident/patient feels unloved, has been rejected, may be depressed, or has suffered a loss</p> <p><i>Overhead – Show Overhead #13.</i></p> <p>How does the health care provider know when a resident/patient is hostile?</p> <ul style="list-style-type: none">• Sarcastic,• Unjustified criticism of staff and facility• Uncooperative, argumentative about trivial things, easily upset, does not want to be bothered, may curse• Throws things, smashes things, kicks things,• Or may be excessively polite (yet conveys dislike for everything and everybody)• When confronted with behavior may act as if he/she does not know what the healthcare provider is talking about <p>Is often avoided because his/her behavior is unpredictable</p> <p><i>Overhead – Show Overhead #14.</i></p>	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a hostile resident/patient.

<u>Content</u>	<u>Notes</u>
<p><u>Approach</u></p> <p>Keep the tone of voice low and well controlled</p> <ul style="list-style-type: none">• React with honest, open, concerned attitude• Must convince resident/patient that health care provider cares <p>Do not take the resident/patient's criticism personally</p> <ul style="list-style-type: none">• Will decrease the chance of becoming defensive• Quietly answer the resident/patient outburst by providing explanation of the function of staff and facility• Strategy is to admit that anger is recognized, but is not really due to the care that health care provider is giving• Stay with resident/patient for few minutes to indicate ease and control• May lead to increasing comfort in the relationship• Example - "I am a nurse aide and my job is to help residents/patients at this facility. I will stay here for a few minutes in case you need to talk with me." <p>Allow the resident/patient the chance to talk and express him/herself, without hurting his/her feelings.</p> <ul style="list-style-type: none">• Example - "You to seem to be upset about having to stay at this facility."• Example of what not to say - "Now, now we don't act that way here." "No wonder no one wants to take care of you."	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for a hostile resident/patient.

<u>Content</u>	<u>Notes</u>
<p>Listen to what the resident/patient has to say</p> <ul style="list-style-type: none">• Be honest with all responses and remain focused on reality• Example – “I know it may seem longer than 10 minutes since you rang your call bell. I’m sorry I could not come in here immediately. What may I help you with.” <p>Avoid excess smiling and flattering remarks</p> <ul style="list-style-type: none">• Resident/patient may think health care provider is making fun of him/her <p>Let resident/patient set the pace</p> <ul style="list-style-type: none">• Keep interactions simple <p>If health care provider fears resident/patient, do not go into the room alone</p> <p>Attempt to direct harmful energy into positive area</p> <ul style="list-style-type: none">• Exercise or sports activity may decrease resident/patient anger	

Objective 5: Select appropriate communication techniques in unique health care situations: caring for an unconscious/comatose resident/patient.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #15.</i></p> <p>Unconscious/comatose- a resident/patient that cannot be aroused and does not respond to stimuli</p> <p>Causes – various disease processes or related to trauma to head</p> <p>How does the health care provider know when a resident/patient is unconscious/comatose?</p> <ul style="list-style-type: none">• Resident/patient will not respond to external stimuli <p><i>Overhead – Show Overhead #16.</i></p> <p><u>Approach</u></p> <ul style="list-style-type: none">• Always assume the resident/patient can hear you• Talk in a normal tone about the care provided that would ordinarily be said to a conscious resident/patient• Speak to the resident/patient before touching• Keep noise level in room as low as possible – so resident/patient can hear better	

Objective 6: I identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<p><i>Handout – Distribute Handout #2.</i></p> <p><i>Overhead – Show Overhead #17.</i></p> <p>The grieving resident/patient</p> <p>Grief is a loss involving someone or something that has a special meaning or significance to the resident/patient</p> <p><u>Dealing with Death & Dying – the 5 Stages</u></p> <p>Denial</p> <ul style="list-style-type: none">• Shock and disbelief, the 1st reaction to loss, serves as a buffer against unexpected and difficult news• Is a defense mechanism to relieve extreme anxiety about disturbing news and allows the resident/patient to not believe that certain information is true – the death of a loved one, the diagnosis of a fatal disease• In this stage, resident/patient has a chance to gather up resources and support system in order to help deal with the disturbing news• Resident/patients do not usually ask many questions and can ignore information that can't be handled• Typical resident/patient responses – "It's not true. She can't be dead. It's someone else." "No, not me. I'm not going to die. They got me mixed up with someone else." <p>Anger</p> <ul style="list-style-type: none">• Anger often directed at others, such as the health	

Objective 6: I identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<p>care provider, "Why couldn't they do more? They never did seem to get her diet right!"</p> <ul style="list-style-type: none"> • Typical resident/patient responses - "Why did my wife have to go to the store in the rain? Why did she have to die so soon?" "Why me? I'm still young. My children need me. Why did I get this disease?" • Anger may also occur if others near the resident/patient are laughing and seem to be happy. <p>Bargaining</p> <ul style="list-style-type: none"> • Is an attempt to postpone death or bring back the dead loved one • Usually a secret bargain with God or a higher power • Often attempt to delay death until an event occurs • Typical resident/patient responses - "Bring her back and take me. She was so much better than me." "If I can just live until my children graduate, I will accept death then." "Please let me live until my children grow up." "If God will let me recover, I'll never drink again." <p>Depression</p> <ul style="list-style-type: none"> • Resident/patient realizes reality - a loved one is really dead, he/she is going to die very soon • Begin to mourn the loss - never seeing a loved one again, loss of control, loss of the future • Demonstrated in various ways - verbalized feelings of hopelessness, crying and weeping, remaining quiet or withdrawing, loss of appetite, inability to sleep, decreased activity 	

Objective 6: Identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<p>Acceptance</p> <ul style="list-style-type: none">• Is not all-or-nothing, but a gradual stage• Issues and struggles with loss are resolved• Dying resident/patient accept their fate and make peace spiritually• Dying resident/patient may detach themselves from activities and spend time with closest friends and relatives <p><i>Overhead – Show Overhead #18.</i></p> <p><u>Approaches</u></p> <p>At times, health care providers have to examine their own feelings and discomfort about death and dying.</p> <p>Sometimes the health care provider just does not know what to say. A caring touch can often communicate , “I am with you. I see your pain. I care.”</p> <p><i>Overhead – Show Overhead #19.</i></p> <p>Nonverbal communication is important</p> <ul style="list-style-type: none">• A caring touch, a smile, or eye contact are meaningful gestures of support and often welcomed, especially if a trusting relationship has developed <p>Provide and encourage opportunities for the resident/patient to discuss feelings or cry</p>	

Objective 6: I identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• A caring health care provider should not be afraid to show his/her emotions – crying with him/her and sharing own experiences with loss and death• Sometimes tears are not sad tears, but happy ones. “Oh, I just got the nicest note from my grandson.”• Resident/patient may need permission to cry• Accept resident/patient remarks about loss• As resident/patient talks, intensity of remarks will lessen, ease him/her into talking about the here and now• Examples of what not to say – “Dry up your eyes.” “Big girls don’t cry.” “You’ll only make it worse by carrying on like this.” <p>Encourage the resident/patient to avoid stimulating group activities during the evening</p> <ul style="list-style-type: none">• Grieving resident/patient often has difficulties sleeping, and any excitement just before bedtime will add to difficulties• Restrict daytime naps• Provide comforting measures in evening - warm milk in the evening, warm bath, soft lights; restrict caffeine intake <p>Maintain eye contact by sitting where health care provider can be seen</p> <ul style="list-style-type: none">• Even though he/she may not wish to talk, the grieving resident/patient feels lost and isolated	

Objective 6: I identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none"> • Direct resident/patient to former interests, but don't rush him/her • Example – "I have five extra minutes and would like to sit with you. I am here for you, if you would like to talk." "Bingo will begin in 10 minutes. I know how much you enjoy playing bingo." <p>Assist the resident/patient to limit thinking to here and now</p> <ul style="list-style-type: none"> • Do not talk about future, because resident/patient will not be able to see that far ahead • Help the resident/patient identify present feelings about the loss (denial, anger) & explain feelings are normal • Example – "It is common for people to find it hard to believe when they lose a loved one." <p>Help the resident/patient lessen guilty feelings about the loss</p> <ul style="list-style-type: none"> • Allow resident/patient to discuss feelings of guilt, but try to limit or focus his/her comments to reality based ones • Do not be argumentative • Example of what to say - "You may have feelings of guilt, but you were there for your wife when she was so sick. You drove her to the doctor, cooked her things she liked to eat, and got her prescriptions filled." 	

Objective 6: I identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Example of what not to say "Listen, don't beat yourself up about your wife's death. It's not your fault. You didn't put a gun to her head. You didn't drive her into a brick wall. It's not your fault." <p><i>Overhead - Show Overhead #20</i></p> <p>Try to take care of incidents that make the resident/patient angry at the time</p> <ul style="list-style-type: none">• Grieving residents/patients often displace feelings of anger related to loss onto minor incidents• Correct the incident immediately so the resident/patient does not dwell on it• Example of what to say - "You seem upset about something. Oh I see, the kitchen sent orange juice instead of grape juice. Let me go exchange the juice right now." <p>Do not judge or reject the resident/patient</p> <ul style="list-style-type: none">• Do not be too quick to view the resident/patient as uncooperative if he/she seems slow at recovering from loss• Grief normally takes about four to eight weeks to resolve, sometimes longer. <p>Express interest in the resident/patient as a person</p> <ul style="list-style-type: none">• Helps resident/patient feel that he/she is being cared for• Example - "Did you sleep well last night?" "How's breakfast going? Is the grape juice cold enough for you?"	

Objective 6: I identify appropriate communication techniques when caring for the resident/patient facing death.

<u>Content</u>	<u>Notes</u>
<p>Do not get defensive if the resident/patient directs his/her anger at the health care provider.</p> <ul style="list-style-type: none">• Anger is a cover for the underlying sadness• It is common for feelings of anger at the loss and often the health care provider is a target.• Do not become defensive because that will only make the anger worse• Accept expressions of anger, yet redirect focus and present reality• Example – “It may seem like it took us an hour to answer your call bell, but I did come in here as soon as I noticed you needed something. What can I do for you?” <p>Encourage resident/patient to express his/her feelings about the loss and attempt to focus on the good times they shared</p> <ul style="list-style-type: none">• Example – “You and your wife liked to travel. Where were some of your favorite places you enjoyed going with her?”	

Objective 7: Recognize the special communication techniques used when caring for a resident/patient with Alzheimer's disease.

<u>Content</u>	<u>Notes</u>
<p><i>Handout - Distribute Handout #3.</i></p> <p><i>Overhead - Show Overhead #21.</i></p> <p><i>Alzheimer's disease</i> is a progressive, deteriorating brain disorder</p> <p>Progression of Disease</p> <ul style="list-style-type: none">• First sign is memory loss of recent information, forgetfulness• Eventually long-term memory loss occurs• Eventually, inability to make appropriate judgments and impaired problem-solving• Finally, during last stages, an inability to perform activities of daily living, becoming totally dependent on others <p><i>Overhead - Show Overhead #22</i></p> <p><i>Environment/Activities</i></p> <ul style="list-style-type: none">• Provide an environment that is structured, dependable routine• Gently approach the resident/patient with an open, friendly, relaxed manner. Resident/patient mirrors the affect of those around them• Seat the resident/patient across the table from others doing a task or eating, so he/she can model the behavior	

Objective 7: Recognize the special communication techniques used when caring for a resident/patient with Alzheimer's disease.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Include resident/patient in group activities, even if he/she doesn't participate• If the resident/patient reacts strongly to a situation, remain calm and remove him/her from the area• Change activities if resident/patient becomes angry, hostile, or uncooperative• Avoid situations that require intellectual skills, such as Quiz Bowls or 20 Questions• Reduce stimuli that interferes with the resident/patient's attention• Encourage resident to reminiscence or think back to past events ("I understand that you were a carpenter.")• If capable, providing limited choices gives the resident/patient a sense of control without overly frustrating him/her ("Would you like to wear your red shirt or green shirt" instead of "Go look in your closet and pick out a shirt.") <p><i>Overhead - Show Overhead #23</i></p> <p><i>Orientation</i></p> <ul style="list-style-type: none">• Attempts to orient to person, place, time should be used with resident/patient with mild to moderate cognitive impairment related to Alzheimer's disease• Incorporate orientation with activities ("Since it's 6:00 would you like to eat supper?")	

Objective 7: Recognize the special communication techniques used when caring for a resident/patient with Alzheimer's disease.

<u>Content</u>	<u>Notes</u>
<p><i>Communication</i></p> <ul style="list-style-type: none">• Get resident/patient's attention by calling his/her name. Health care provider should always identify him/herself• Speak in a clear, low-pitched voice• Use short and simple words, sentences, and questions.• Keep explanations or directions short and simple• Use yes/no questions and avoid those requiring choices• Ask one question at a time and involve resident/patient with one idea or task at a time <p><i>Overhead - Show Overhead #24</i></p> <ul style="list-style-type: none">• Allow resident/patient time to respond to questions• Break down tasks into individual steps and ask the resident/patient to do them one at a time• Provide gentle reminders or demonstrate the action desired• Watch resident/patient's nonverbal behavior for clues of discomfort or distress, because the resident/patient may not be able to verbalize these feelings <p><i>Written Activity - Distribute Written Activity #1 to participants.</i></p> <p><i>Discussion - Upon completion of Written Activity #1, discuss answers with participants.</i></p>	

WRITTEN ACTIVITY

For

***ADVANCED
COMMUNICATION***

Part 2

**Advanced Communication Skills
Part Two Written Activity #1**

Read the following statements that were overheard on Nursing Unit C. Decide which resident/patient most likely made each statement and put his/her name on the blank statement - **Anxious Annie, Hostile Horace, Debbie Depressed, Grover Grief, Connie Coma, and Delores Delirious.** You have 10 minutes to complete this activity.

1. "Why did she have to die? She was a good woman."

2. "I ought to smash your face for bringing me cold oatmeal."

3. "My heart is just racing away. Why are my palms sweaty?"

4. "Sometimes I want to end it all. Boo Hoo Hoo."

5. Silence

6. "Where am I? Who are you? What time is it?"

7. "Your teacher was right. I can hear you, but just can't respond."

8. "Boy, my head hurts. How did I get that bump on my head?"

9. "Oh shut up. I didn't ask you your opinion."

10. "Please let me live to see the birth of my child."

Advanced Communication Skills
Part Two Written Activity #1

ANSWER KEY

Read the following statements that were overheard on Nursing Unit C. Decide which resident/patient most likely made each statement and put his/her name on the blank statement - Anxious Annie, Hostile Horace, Debbie Depressed, Grover Grief, Connie Coma, and Delores Delirious. You have 10 minutes to complete this activity.

1. "Why did she have to die? She was a good woman."

Grover Grief, Debbie Depressed

2. "I ought to smash your face for bringing me cold oatmeal."

Hostile Horace

3. "My heart is just racing away. Why are my palms sweaty?"

Anxious Annie

4. "Sometimes I want to end it all. Boo Hoo Hoo."

Debbie Depressed, Grover Grief

5. Silence

Debbie Depressed, Grover Grief

6. "Where am I? Who are you? What time is it?"

Delores Delirious

7. "Your teacher was right. I can hear you, but just can't respond."

Connie Coma

8. "Boy, my head hurts. How did I get that bump on my head?"

Debbie Delirious

9. "Oh, shut up. I didn't ask you your opinion."

Hostile Horace

10. "Please let me live to see the birth of my child."

Debbie Depressed

HANDOUTS

For

***ADVANCED
COMMUNICATION***

Part 2

Advanced Communication Handout #1

Appropriate Communication Techniques in Unique Health Care Situations: Anxious Resident/Patient

Anxiety is a feeling of uneasiness or dread that occurs as a response to a perceived threat

Possible causes – being admitted to a nursing home or hospital and all that it entails

How does the health care provider know when a resident/patient is anxious?

- Excessive perspiration including sweaty hands
- Wringing of the hands, tremors
- Repetitious questioning, continually forgetting things, short attention span, difficulty in concentrating, restlessness
- Difficulty in sleeping
- Rapid pulse, racing heart
- Dilated pupils
- Diarrhea, urinary frequency
- Indigestion
- May be tearful, easily angered, have frequent complaints, be overly happy, or irritable
- May frequently use call bell

Everyone has periods of anxiety. The degree of anxiety determines whether it is positive or negative

Approaches:

Be understanding of resident/patient's feelings

- Lets him/her know health care provider recognizes that he/she is anxious
- Example?

When approaching the resident/patient, speak slowly, briefly, and concretely

- Will increase the likelihood that resident/patient will understand what is said
- Example?

Do not use meaningless phrases

- Make the resident/patient feel less important
- Example?

Use measures to increase the resident/patient's comfort

- Provide comforting measures - warm milk, warm bath, soft lights, back rubs; restrict caffeine intake

Tell the resident/patient you are concerned about his/her feelings.

- Acknowledge difficult time resident/patient is having
- Example?
- Example of what not to say?

Encourage the resident/patient to verbalize his feelings about what he/she remembers that happened before he/she became anxious.

Don't offer suggestions as to the possible causes of the residents/patient's anxiety.

May increase anxiety because the resident/patient is focusing on the cause

- Example of what not to say?

Do not make demands on the resident/patient, when anxiety level is high

- More stress on the resident will increase anxiety
- Example of what not to say?

Do not try to reassure the resident/patient with empty explanations

- Makes the resident/patient feel less important
- Example of what not to say?

Do not dwell on what the resident/patient is doing to relieve tension.

- Resident/patient may be using call bell frequently, walking to the nurses station frequently
- Examples of what not to say?

Do not become defensive when the resident/patient complains

- May complain about everything and anything that health care provider does
- Encourage resident/patient to identify what events preceded his/her anxiety
- Example of what not to say?

And,

Do not be surprised if logic is useless

Do not expect the resident/patient to change his/her behavior immediately.

Appropriate Communication Techniques in Unique Health Care Situations: Depressed Resident/Patient

Reactive depression is a self-limiting depressed state that lessens or disappears when circumstances change or there is help from supportive others

Possible causes – death of a loved one, loss of a body part, diagnosis of an incurable disease

How does the health care provider know when a resident/patient has reactive depression?

- Decreased interest in surroundings, boredom
- Tendency to continually talk or ponder the loss
- May feel helpless
- May cry, weep, scream, wail, or whine

Major Depression is a sad mood for which there is no obvious relationship to situational events

Possible causes - shortage of certain chemicals in the brain, neglect or rejection as a baby, learned feelings of helplessness, continual exposure to discrimination, distorted or false view of self

How does the health care provider know when a resident/patient has major depression?

- **Sad mood**
- **Appetite change** – increased or decreased
- **Disturbed sleep** – too much or too little

- **Inability to concentrate**
- **Marked decrease in pleasure**
- **Apathy**
- **Guilty feelings**
- **Energy changes** – restlessness or inactivity
- **Suicidal thoughts**

Approaches

Make initial contact with the resident/patient and share perceptions

- Shows caring behavior
- Example?

Tell the resident/patient that you understand and recognize his/her feelings.

- Shows caring behavior
- Example?

Let the resident/patient know that you feel he/she is worthy

- Do not overdo the flattery
- Example?

Show the resident/patient you care about him/her

- Sit with resident/patient, accept silences, tolerate tears

Pay attention to the resident/patient's personal hygiene

- Offer assistance and direction
- Do not criticize
- Example?

Plan activities according to his/her degree of depression

- Tasks should be simple, should not require concentration
- Example?

Resident/Patient Statements & Responses:

What can the healthcare provider say to a resident/patient that is crying?

"I care about you and how difficult this time is for you. Crying sometimes helps when dealing with these types of situations."

What can the health care provider say to the resident/patient that requests something that he/she can not do at the moment?

"I can not walk in the hall with you now, but I will be free to do so in an hour."

What do you do if the resident/patient threatens suicide?

I immediately report statements to the supervisor.

Appropriate Communication Techniques in Unique Health Care Situations: Delirious Resident/Patient

Delirium is a sudden, temporary state of confusion

Causes – high fever, head trauma, brain tumor, certain medications, unfamiliar surroundings, illness, sundown

How does the health care provider know when a resident/patient is delirious?

- Resident/patient is not oriented to person, place, and/or time

Response

- *Orient the resident/patient to his/her surroundings using verbal reminders, clocks, watches, calendar, newspaper*

Example?

- *Speak calmly and use simple words and statements*

Example?

- *Place familiar objects near the resident/patient*
- *Use frequent face-to-face contact when communicating*
- *May try touch, a hug, or a backrub (when appropriate)*
- *Allow resident/patient plenty of time to respond*

Appropriate Communication Techniques in Unique Health Care Situations: **Hostile Resident/Patient**

Hostile is the act of feeling or showing hatred or malice towards someone or something

When it Occurs – resident/patient feels unloved, has been rejected, may be depressed, or has suffered a loss

How does the health care provider know when a resident/patient is hostile?

- Sarcastic,
- Unjustified criticism of staff and facility
- Uncooperative, argumentative about trivial things, easily upset, does not want to be bothered, may curse
- Throws things, smashes things, kicks things,
- Or may be excessively polite (yet conveys dislike for everything and everybody)
- When confronted with behavior may act as if he/she does not know what the healthcare provider is talking about

Is often avoided because his/her behavior is unpredictable

Response

Keep the tone of voice low and well controlled

- React with honest, open, concerned attitude
- Must convince resident/patient that health care provider cares

Do not take the resident/patient criticism personally

- Will decrease the chance of becoming defensive
- Quietly answer the resident/patient outburst by providing explanation of function of staff and facility
- Strategy is to admit that anger is recognized, but is not really due to the care that health care provider is giving
- Stay with resident/patient for few minutes to indicate ease and control

- May lead to increasing comfort in the relationship
- Example?

Allow the resident/patient the chance to talk and express his/herself, without hurting his/her feelings.

- Example?
- Example of what not to say?

Listen to what the resident/patient has to say

- Be honest with all responses and remain focused on reality
- Example?

Avoid excess smiling and flattering remarks

- Resident/patient may think health care provider is making fun of him/her

Let resident/patient set the pace

- Keep interactions simple

If health care provider fears resident/patient, he/she should not go into the room alone

Attempt to direct harmful energy into positive area

- Exercise or sports activity may decrease resident/patient anger

Appropriate Communication Techniques in Unique Health Care Situations:
Unconscious/Comatose Resident/Patient

Unconscious/comatose when a resident/patient cannot be aroused and does not respond to stimuli

When it Occurs – various disease processes or related to trauma to head

How does the health care provider know when a resident/patient is anxious?

- Resident/patient will not respond to external stimuli

Response

Always assume the resident/patient can hear you

Talk in a normal tone about the care provided that would ordinarily be said to a conscious resident/patient

Speak to the resident/patient before touching

Keep noise level in room as low as possible – so resident/patient can hear better

Advanced Communication Handout #2

Appropriate Communication Techniques When Caring for the Resident/ Patient Dealing with Death

Grieving is a loss involving someone or something that has a special meaning or significance to the resident/patient

Dealing with Death & Dying – the 5 Stages:

Denial

- Shock and disbelief, the 1st reaction to loss, serves as a buffer against unexpected and difficult news
- Is a defense mechanism to relieve extreme anxiety about disturbing news and allows the resident/patient to not believe that certain information is true – the death of a loved one, the diagnosis of a fatal disease
- In this stage, resident/patient has a chance to gather up resources and support system in order to help deal with the disturbing news
- Resident/patients do not usually ask many questions and can ignore information that can't be handled
- Typical resident/patient responses – “It’s not true. She can’t be dead. It’s someone else.” “No, not me. I’m not going to die. They got me mixed up with someone else.”

Anger

- Anger often directed at others, such as the health care provider, “Why couldn’t they do more? They never did seem to get her diet right!”
- Typical resident/patient responses - “Why did my wife have to go to the store in the rain? Why did she have to die so soon?” “Why me? I’m still young. My children need me. Why did I get this disease?”
- Anger may also occur if others near the resident/patient are laughing and seem to be happy.

Bargaining

- Is an attempt to postpone death or bring back the dead loved one
- Usually a secret bargain with God or a higher power
- Often attempt to delay death until an event occurs
- Typical resident/patient responses – “Bring her back and take me. She was so much better than me.” “If I can just live until my children graduate, I will accept death then.” “Please let me live until my children grow up.” “If God will let me recover, I’ll never drink again.”

Depression

- Resident/patient realizes reality – a loved one is really dead or he/she is going to die very soon
- Begin to mourn the loss – never seeing a loved one again, loss of control, loss of the future
- Demonstrated in various ways – verbalized feelings of hopelessness, crying and weeping, remaining quiet or withdrawing, loss of appetite, inability to sleep, decreased activity

Acceptance

- Is not all-or-nothing, but a gradual stage
- Issues and struggles with loss are resolved
- Dying resident/patient accept their fate and make peace spiritually
- Dying resident/patient may detach themselves from activities and spend time with closest friends and relatives

Approach

At times, health care providers have to examine their own feelings and discomfort about death and dying

Sometimes health care provider just does not know what to say. A caring touch can often communicate , “I am with you. I see your pain. I care.”

Nonverbal communication is important

- A caring touch, a smile, or eye contact are meaningful gestures of support and often welcomed, especially if a trusting relationship has developed

Provide and encourage opportunities for the resident/patient to discuss feelings or cry

- A caring health care provider should not be afraid to show his/her emotions – crying with him/her and sharing own experiences with loss and death
- Sometimes tears are not sad tears, but happy ones. “Oh, I just got the nicest note from my grandson.”
- Resident/patient may need permission to cry
- Accept resident/patient remarks about loss
- As resident/patient talks, intensity of remarks will lessen, ease him/her into talking about the here and now
- Examples of what not to say?

Encourage the resident/patient to avoid stimulating group activities during the evening

- Grieving resident/patient often has difficulties sleeping and any excitement just before bedtime will add to difficulties
- Restrict daytime naps
- Provide comforting measures in evening - warm milk in the evening, warm bath, soft lights; restrict caffeine intake

Maintain eye contact by sitting where health care provider can be seen

- Even though he/she may not wish to talk, the grieving resident/patient feels lost and isolated
- Direct resident/patient to former interests, but don't rush him/her
- Example?

Assist the resident/patient to limit thinking to here and now

- Do not talk about future, because resident/patient will not be able to see that far ahead

- Help the resident/patient identify present feelings about the loss (denial, anger) & explain feelings are normal
- Example?

Help the resident/patient lessen guilty feelings about the loss

- Allow resident/patient to discuss feelings of guilt, but try to limit or focus his/her comments to reality based ones
- Do not be argumentative
- Example?
- Example of what not to say?

Try to take care of incidents that make the resident/patient angry at the time

- Grieving resident/patient often displace feelings of anger related to loss, onto minor incidents
- Correct the incident immediately so the resident/patient does not dwell on it
- Example?

Do not judge or reject the resident/patient

- Do not be too quick to view the resident/patient as uncooperative if he/she seems slow at recovering from loss
- Grief normally takes about four to eight weeks to resolve, but sometimes longer

Express interest in the resident/patient as a person

- Helps resident/patient feel that he/she is being cared for
- Example?

Do not get defensive if the resident/patient directs his/her anger at the health care provider

- Anger is a cover for the underlying sadness

- Feelings of anger at the loss are common, and often the health care provider is a target
- Do not become defensive because that will only make the anger worse
- Accept expressions of anger, yet redirect focus and present reality
- Example?

Encourage resident/patient to express his/her feelings about the loss and attempt to focus on the good times they shared

- Example?

Advanced Communication Handout #3

Special Communication Techniques – Patient/Resident With Alzheimer's Disease.

Alzheimer's disease is a progressive, deteriorating brain disorder

How does the health care provider know when a resident/patient has Alzheimer's disease?

- First sign is memory loss of recent information, forgetfulness
- Eventually long-term memory loss occurs
- Eventually, inability to make appropriate judgments and has impaired problem-solving skills
- Finally, during last stages, an inability to perform activities of daily living, becoming totally dependent on others

Approaches:

Environment/Activities

- Provide an environment that is structured, dependable routine
- Gently approach the resident/patient with an open, friendly, relaxed manner. Resident/patient mirrors the affect of those around them
- Seat the resident/patient across the table from others doing a task or eating, so he/ she can model the behavior
- Include resident/patient in group activities, even if he/she doesn't participate
- If the resident/patient reacts strongly to a situation, remain calm and remove him/her from the area
- Change activities if resident/patient becomes angry, hostile, or uncooperative
- Avoid situations that require intellectual skills, such as Quiz Bowls or 20 Questions
- Reduce stimuli that interfere with the resident/patient's attention
- Encourage resident to reminiscence or think back to past events ("I understand that you were a carpenter.")

- If capable, providing limited choices gives the resident/patient a sense of control without overly frustrating him/her ("Would you like to wear your red shirt or green shirt" instead of "Go look in your closet and pick out a shirt.")

Orientation

- Attempts to orient to person, place, time should be used with resident/patient with mild to moderate cognitive impairment related to Alzheimer's disease
- Incorporate orientation with activities ("Since it's 6:00 would you like to eat supper?")

Communication

- Get resident/patient's attention by calling his/her name. Health care provider should always identify him/herself
- Speak in a clear, low-pitched voice
- Use short and simple words, sentences, and questions
- Keep explanations or directions short and simple
- Use yes/no questions and avoid those requiring choices
- Ask one question at a time and involve resident/patient with one idea or task at a time
- Allow resident/patient time to respond to questions
- Break down tasks into individual steps and ask the resident/patient to do them one at a time
- Provide gentle reminders or demonstrate the action desired
- Watch resident/patient's nonverbal behavior for clues of discomfort or distress, because the resident/patient may not be able to verbalize these feelings

OVERHEADS

For

***ADVANCED
COMMUNICATION***

Part 2

Appropriate Communication Anxious Resident/Patient

Anxiety is a feeling of uneasiness
or dread that occurs as a
response to a perceived threat



**Possible causes - admission to
nursing home or hospital**

Appropriate Communication

Anxious Resident/Patient

How do you know?

- Excessive perspiration
- Wringing of hands, tremors
- Repetitious questioning, continually forgetting things, short attention span, difficulty in concentrating, restlessness
- Difficulty in sleeping
- Racing pulse & racing heart
- Dilated pupils
- Diarrhea, urinary frequency
- Indigestion
- May be tearful, easily angered, have frequent complaints, be overly happy, or irritable
- May frequently use call bell

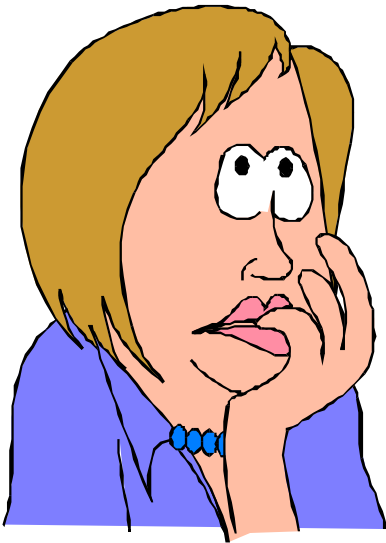


Appropriate Communication Anxious Resident/Patient

Everyone has periods of anxiety.
The degree of anxiety determines
whether it is positive or negative

Approaches - Do's

- *Be understanding of feelings*
- *Speak slowly, briefly, concretely*
- *Use measures to increase comfort*
- *Speak of concern about feelings*
- *Encourage verbalization of feelings about events before anxiety*



Appropriate Communication Anxious Resident/Patient

Approaches - Don'ts

- *Don't use meaningless phrases*
- *Don't offer suggestions as to causes of anxiety*
- *Don't make demands when anxiety level is high*
- *Don't try to reassure with empty explanations*
- *Don't dwell about methods to relieve tension*
- *Don't become defensive with complaints*
- *Don't be surprised if logic is useless*
- *Don't expect changes in behavior immediately.*

Appropriate Communication Depressed Resident/Patient

Reactive depression is a self-limiting depressed state that lessens or disappears when circumstances change or there is help from supportive others

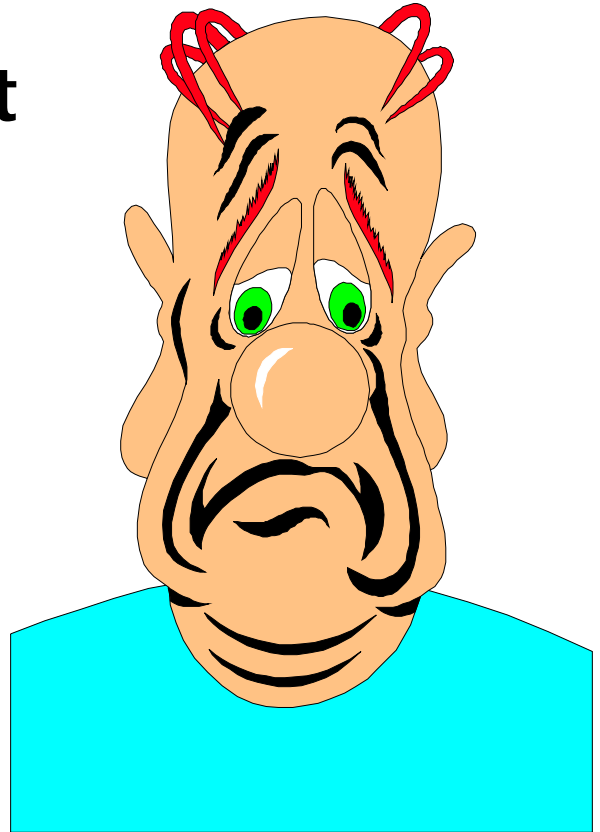


Possible causes - death of loved one, loss of body part, diagnosis of an incurable disease

Appropriate Communication Depressed Resident/Patient

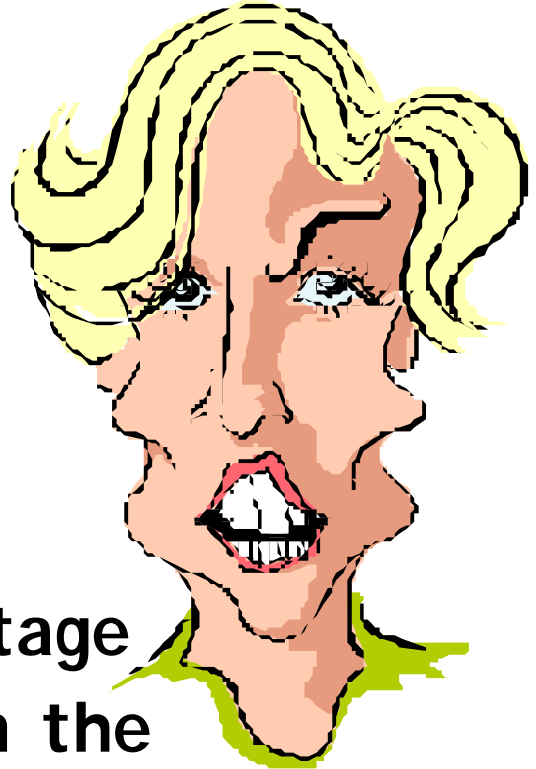
Reactive Depression - How Do You Know?

- Decreased interest in surroundings, boredom
- Tendency to continually talk or ponder the loss
- May feel helpless
- May cry, weep, scream, wail, or whine



Appropriate Communication Depressed Resident/Patient

Major depression is a sad mood for which there is no obvious relationship to situational events



Possible causes - shortage of certain chemicals in the brain, neglect or rejection as a baby, learned feelings of helplessness, continual exposure to discrimination, distorted or false view of self

Appropriate Communication Depressed Resident/Patient

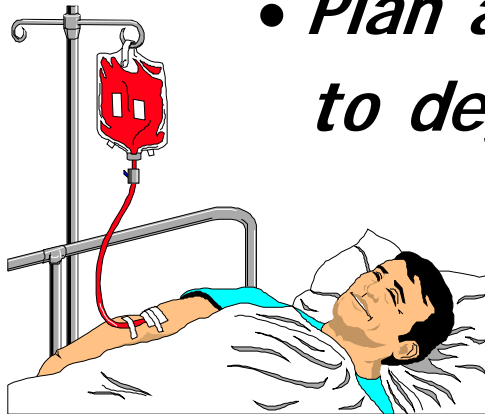
Major Depression – How Do You Know?

- **S**ad mood
- **A**ppetite change – increased or decreased
- **D**isturbed sleep – too much or too little
- **I**nability to concentrate
- **M**arked decrease in pleasure
- **A**pathy
- **G**uilty feelings
- **E**nergy changes – restlessness or inactivity
- **S**uicidal thoughts

Appropriate Communication Depressed Resident/Patient

Approaches

- *Make initial contact & share perceptions*
- *Say that you care about and recognize feelings.*
- *Say that he/she is worthy*
- *Show that you care*
- *Pay attention to personal hygiene*
- *Plan activities according to degree of depression*



What If. . . Statements & Responses?

Appropriate Communication Delirious Resident/Patient

Delirium is a sudden, temporary
state of confusion

Causes – high fever,
head trauma, brain
tumor, certain
medications, unfamiliar
surroundings, illness, sundown



How do you know?

Resident/patient isn't oriented to
person,

place,

time



Appropriate Communication Delirious Resident/Patient

Approaches

*Orient to surroundings using
verbal reminders, clocks,
watches, calendar, newspaper*

*Speak calmly/use simple
words and statements*

Place familiar objects nearby

*Use frequent face-to-face
contact when communicating*

*May try touch,
a hug, or a backrub*

Allow plenty of time to respond

Appropriate Communication Hostile Resident/Patient

Hostile is the act of feeling or showing hatred or malice towards someone or something



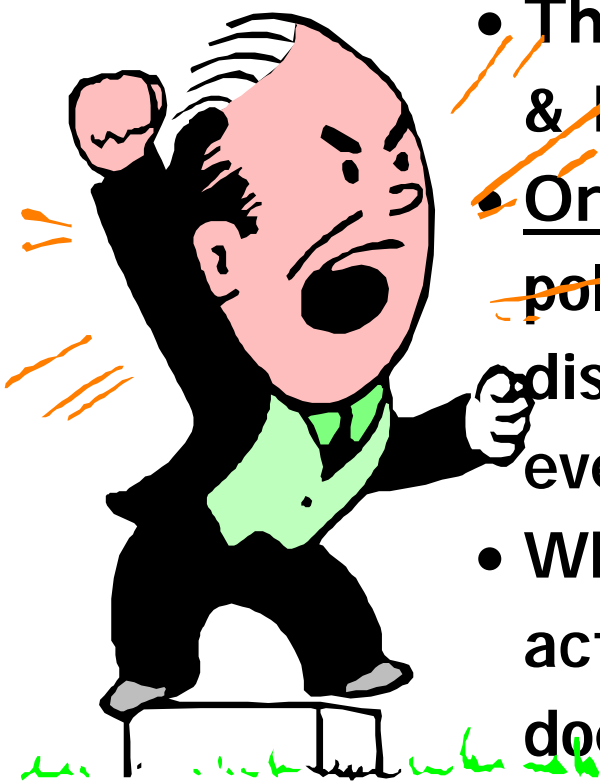
Causes - feels unloved, has been rejected, may be depressed, or suffered a loss

Appropriate Communication

Hostile Resident/Patient

How do you know?

- Sarcastic
- Unjustified criticism of staff/facility
- Uncooperative, argumentative about trivial things, easily upset, does not want to be bothered, may curse



- Throws/smashes & kicks things
- Or may be excessively polite (yet conveys dislike for everything/everybody)
- When confronted may act as though he/she does not know what is going on

Appropriate Communication Hostile Resident/Patient

Is often avoided because his/her
behavior is unpredictable

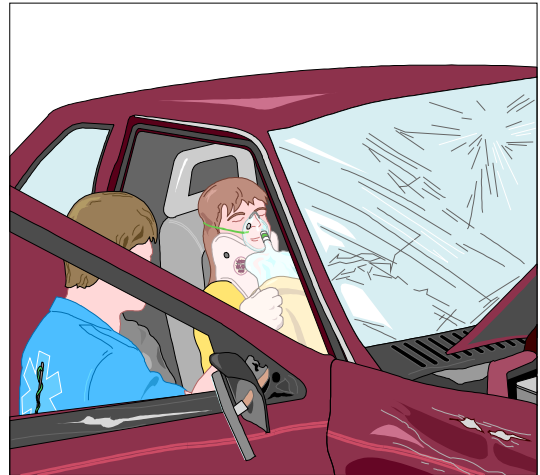
Approaches

- *Keep tone of voice low/well controlled*
- *Do not take the criticism personally*
- *Allow the chance to talk and express self, without hurt feelings*
- *Listen*
- *Do not smile a lot or flatter*
- *Allow to set the pace*
- *If frightened, do not enter room alone*
- *Attempt to direct harmful energy*

Appropriate Communication Unconscious Resident/Patient

Unconscious/comatose – when a resident/patient cannot be aroused and does not respond to stimuli

Causes – various disease processes or related to head trauma



How do you know?

Will not respond

to external stimuli

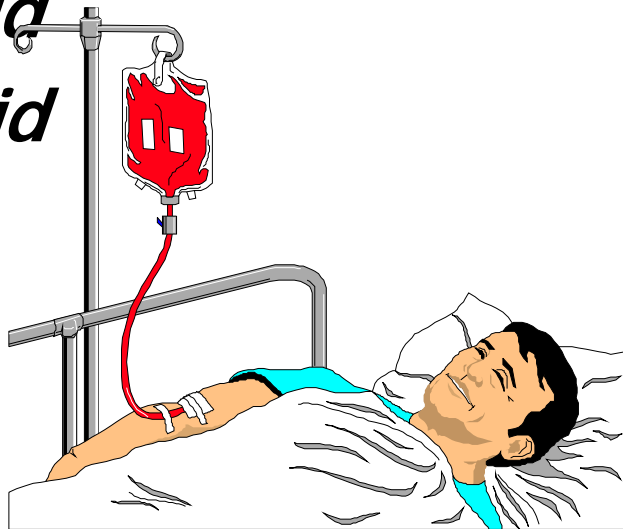
Appropriate Communication Unconscious Resident/Patient

Approaches

Always assume you will be heard

*Talk in a normal tone about
things that would
ordinarily be said*

*Speak before
touching*



Keep noise level in room low

Death & Dying

Grieving is a loss that involves someone or something that has a special meaning or significance

Dealing with Death & Dying

The Five Stages

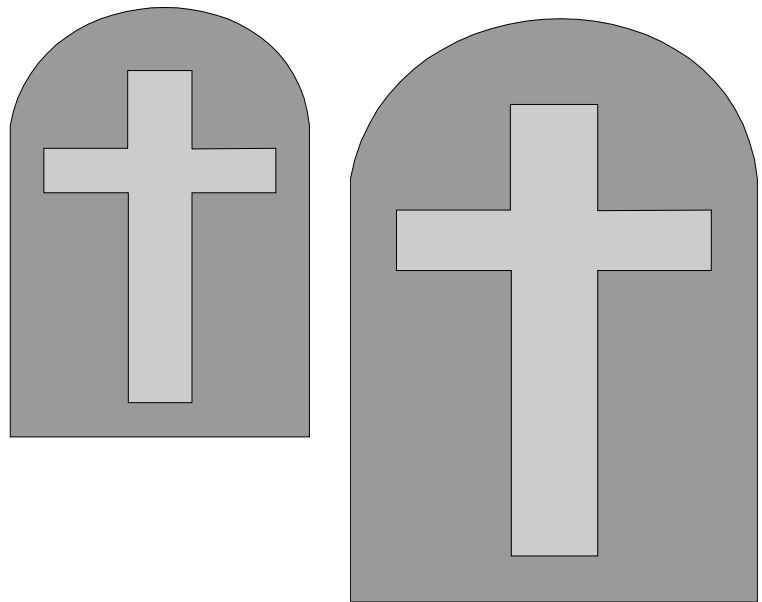
Denial

Anger

Bargaining

Depression

Acceptance



Death & Dying

Approaches

*At times, health care providers
have to examine their own feelings
and discomfort about
death and dying*

*Sometimes the health care provider
just does not know what to say. A
caring touch can often
communicate,
"I am with you. I see your pain.
I care."*

Death & Dying

Approaches

- *Nonverbal communication is important*
- *Provide and encourage opportunities to discuss feelings or cry*
- *Avoid stimulating group activities during the evening*
- *Maintain eye contact*
- *Limit thinking to here and now*
- *Help lessen guilty feelings about the loss*

Death & Dying

Approaches

- *Try to take care of incidents that make the resident/patient angry at the time*
- *Do not judge or reject*
- *Express interest*
- *Do not get defensive if anger is directed at health care provider*
- *Encourage expression of feelings about the loss and attempt to focus on the good times they shared*

Special Communication Techniques

Alzheimer's Disease

***Alzheimer's disease* is a progressive, deteriorating brain disorder**

Progression of Disease

- **First sign is memory loss of recent information, forgetfulness**
- **Eventually long-term memory loss occurs**
- **Eventually, inability to make appropriate judgments and impaired problem-solving**
- **Finally, during last stages, an inability to perform activities of daily living and becomes totally dependent on others**

Alzheimer's Disease

Environment/Activities

- **Structured environment with a dependable routine**
- **Gently approach with an open, friendly, relaxed manner**
- **Seat across the table from others doing a task or eating**
- **Include group activities, even if no participation**
- **If the resident/patient reacts strongly to situation, remain calm & remove from area**
- **Change activities if resident/patient becomes angry, hostile, or uncooperative**
- **Avoid situations that require intellectual skills**
- **Reduce stimuli that interfere with attention**
- **Encourage to reminiscence or think back to past events**
- **If capable, provide limited choices**

Alzheimer's Disease

Orientation

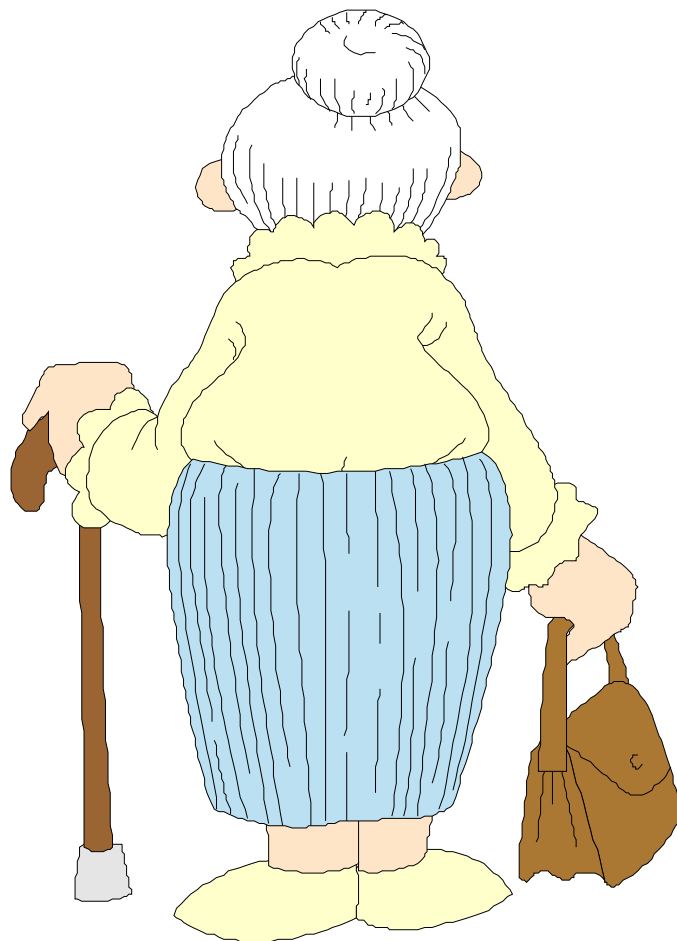
- Attempts to orient to person, place, time should be used with mild to moderate cognitive impairment related to Alzheimer's disease
- Incorporate orientation with other activities

Communication

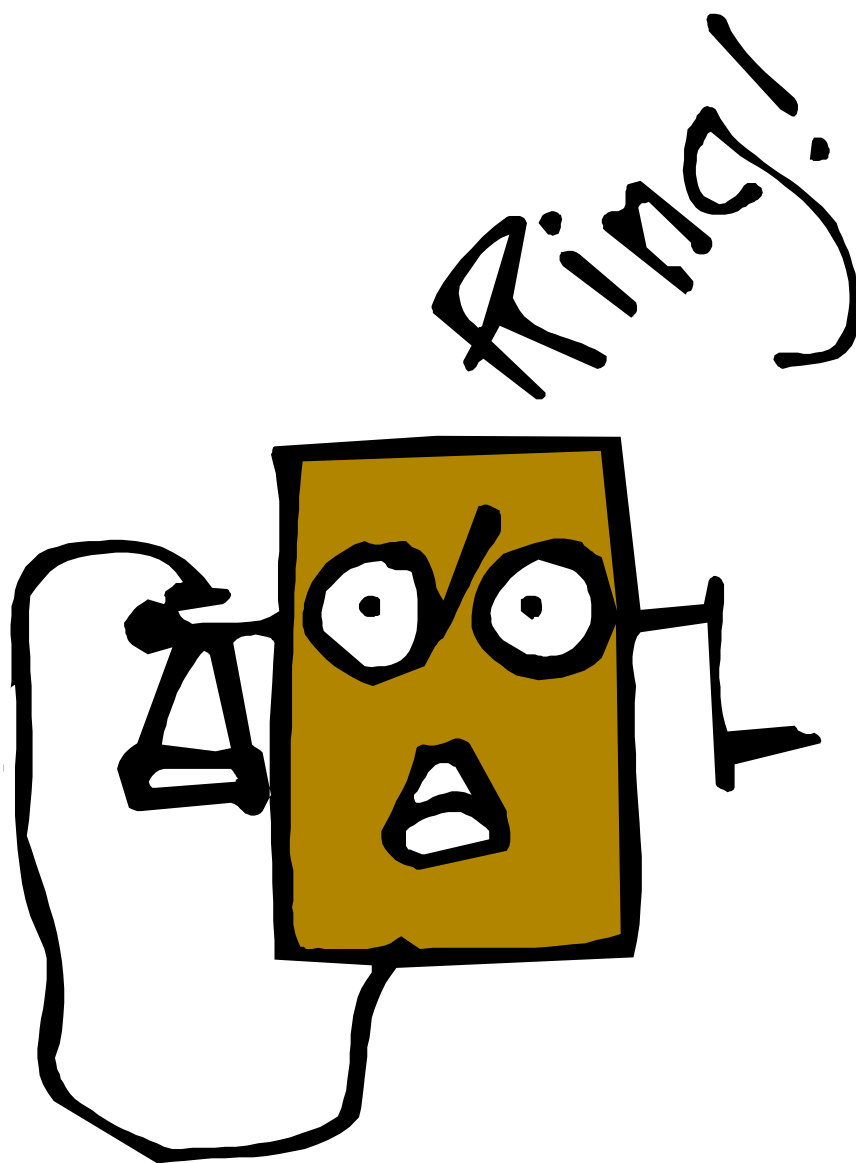
- Get attention by calling name. Health care provider should always identify self
- Speak in a clear, low-pitched voice
- Use short and simple words, sentences & questions.
- Keep explanations or directions short and simple
- Use yes/no questions and avoid those requiring choices
- Ask one question at a time and involve with one idea or task at a time

Alzheimer's Disease

- Allow time to respond to questions
- Break down tasks into individual steps and ask to do them one at a time
- Provide gentle reminders or demonstrate the action desired
- Watch nonverbal behavior for clues of discomfort or distress, because of inability to verbalize feelings



Advanced Communication Skills Curriculum Module



Part Three

Objective 8: Define culture, ethnicity, and race.

<u>Content</u>	<u>Notes</u>
<p><i>Handout - Distribute Handout #1</i></p> <p><i>Overhead - Show Overhead #1</i></p> <p>Culture is a view of the world as well as a set of values, beliefs, and traditions that are handed down from generation to generation:</p> <ul style="list-style-type: none">• Often foundation for language, communication style, customs, religion, health beliefs, and health characteristics• Tend to share biological and physiological characteristics (some cultures at greater risk of developing certain health conditions/diseases) <p><i>Overhead - Show Overhead #2</i></p> <p>Ethnicity is the bond or kinship people feel with their country of birth or place of ancestral origin:</p> <ul style="list-style-type: none">• Based on socialization and not on biological traits• Some people very proud of their particular heritage• Examples, wearing certain items of clothing, giving children ethnic names, appreciating ethnic music, and eating native foods <p><i>Overhead - Show Overhead #3</i></p> <p>Race is the biologic variation:</p> <ul style="list-style-type: none">• Originally included four divisions worldwide - Mongoloid, Negroid, Caucasoid, and Australoid• Based on differences in obvious physical features such as eye shape, skin color, and hair texture	

Objective 8: Define culture, ethnicity, and race.

Content

- Racial mixing has blurred differences among races
- Important not to associate skin color with culture because it may lead to wrongly assume that all people with certain physical attributes share the same culture and have cultural values, beliefs, and practice different from those of the Anglo-American culture.

Notes

Objective 9: Define the term subculture and describe different subcultures that are a part of American culture.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #4</i></p> <p>Anglo-American is the dominant culture of America:</p> <ul style="list-style-type: none">• Originated from western European countries• Often described as white and Anglicized (English-based) because of the culture of early British settlers• Not all people living in America accept the entire Anglo-American culture <p><i>Overhead – Show Overhead #5</i></p> <p>Subculture refers to a unique cultural group that coexists With a dominant culture.</p> <p>Major American subcultures based on ethnic background Include:</p> <ul style="list-style-type: none">• African American subculture<ul style="list-style-type: none">- originating from Africa, Haiti, Jamaica, West Indian Islands, and Dominican Republic- 12.1% of American population (1990 census)• Latino subculture<ul style="list-style-type: none">- originating from Mexico, Puerto Rico, Cuba, South America, Central America- ancestry is from Spain- 9% of American population (1990 census)• Asian American<ul style="list-style-type: none">- originating from China, Japan, Korea, Philippines, Thailand, Indochina, Vietnam, Pacific Islands- 2.9% of American population (1990 census)	

Objective 9: Define the term subculture and describe different subcultures that are a part of American culture.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Native Americans subculture<ul style="list-style-type: none">- includes the North American Indian nation and tribes including Eskimos and Aleuts- 0.8% of American population (1990 census) <p><i>Instructor Note:</i> Discuss how populations in North Carolina may be different than the 1990 Census figures. For example, increase in Hispanic Population. How does this affect the nurse aide? The patient/resident?</p>	

Objective 10: List cultural building blocks and cultural stumbling blocks when working with people from other cultures.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #6</i></p> <p>Cultural building blocks</p> <ul style="list-style-type: none">• Cultural sensitivity – when an individual becomes aware of, recognizes, acknowledges, and values that behavior patterns differ between ethnic groups and within ethnic groups• Cultural relativism – when an individual strives to understand the resident/patient's behavior within their own cultural system• Cultural negotiation – when the health care provider accommodates or modifies the health care system to permit inclusion of health practices and beliefs of the resident/patient <p>nosy</p> <p>Cultural stumbling blocks</p> <ul style="list-style-type: none">• Prejudice – hostile attitude toward an individual because he/she belongs to a specific, racial, ethnic, or religious group• Ethnocentrism – the belief that one's own ethnic culture is the standard and superior to all others• Discrimination – treating an individual differently because he/she belongs to a specific, racial, ethnic, or religious group• Racism – is the combination of prejudice and discrimination• Stereotyping – is a fixed attitude, idea, opinion, or belief about all people who share a common characteristic, such as age, race, religion, or culture	

Objective 10: List cultural building blocks and cultural stumbling blocks when working with people from other cultures.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">• Cultural imposition – imposing personal beliefs, values, and practices on another individual or group• Cultural blindness – seeing all cultures as the same• Cultural conflict – anxiety experienced by a person when he/she interacts with individuals who have different beliefs, values, customs, and languages than his/her own• Cultural shock – state of disorientation, confusion, frustration, and a feeling of helplessness produced by being in a culture different from one's own	

Objective 11: Describe transcultural nursing and provide examples of its use when relating to residents/patients from different subcultures.

<u>Content</u>	<u>Notes</u>
<p><i>Handout - Distribute Handout #2</i></p> <p><i>Overhead - Show Overhead #7</i></p> <p>Transcultural nursing is nursing care provided within the context of another's culture:</p> <ul style="list-style-type: none"> • Culturally sensitive • Accepts each resident/patient as an individual • Based on knowledge of health problems that affect particular cultural groups • Care planned with the resident/patient's health belief system in mind <p><i>Overhead - Show Overhead #8</i></p> <p>Examples</p> <ul style="list-style-type: none"> • Demonstrate respect • Greet the resident/patient respectfully. Use title (Mr., Mrs., Miss) and the person's last name. Attempt to pronounce his/her name correctly. Health care provider should state his/her name slowly <ul style="list-style-type: none"> - Follow appropriate cultural preferences (eye contact, distance) <p><i>Overhead - Show Overhead #9</i></p> <ul style="list-style-type: none"> • Communicate in a non-threatening manner <ul style="list-style-type: none"> - Approach slowly and wait for acknowledgment - Project calmness 	

Objective 11: Describe transcultural nursing and provide examples of its use when relating to residents/patients from different subcultures.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none">- Try not to stand over the resident/patient and when possible, sit a comfortable distance away from the resident/patient and lean forward. Do not interrupt, avoid changing subject, nod occasionally, acknowledge anxiety or fear- Provide the resident/patient with a quiet setting and privacy. May want family members present <p><i>Overhead – Show Overhead #10</i></p> <ul style="list-style-type: none">• Adopt special approaches when resident/patient speaks a different language<ul style="list-style-type: none">- Use a caring tone of voice and facial expression- Speak slowly and distinctly, but not loudly- Repeat message in different ways as needed- Focus on a single idea or experience- Allow silence- Note words that resident/patient seems to understand & use frequently- Keep messages simple and repeat often- Avoid medical terms and abbreviations. Pay attention to nonverbal behavior- Use a language dictionary if available	

Objective 12: Apply culturally appropriate verbal and nonverbal communication techniques when caring for members of the African American, Native American, Asian American, and Latino subcultures.

<u>Content</u>	<u>Notes</u>
<p><i>Handout - Distribute Handout #3</i></p> <p><i>Overhead - Show Overhead #11</i></p> <p><u>Verbal & Nonverbal Differences Among Subcultures</u></p> <p>Native Americans</p> <ul style="list-style-type: none"> • Rather private people • May be hesitant to share personal information with a stranger & often interpret questioning by the health care provider as nosy or meddling • View listening as a valued skill. • View impatience as disrespectful • Note taking by health care provider - considered insulting because health care provider not paying full attention to the conversation, or suspicious because history preserved by verbal stories, rather than the written word <p><i>Overhead - Show Overhead #12</i></p> <ul style="list-style-type: none"> • Disrespectful to call older adults by first name • May not speak up and say that a part of the conversation was not heard (considered rude or impolite) • Low tone of voice is considered respectful • Eye contact - prolonged eye contact is rude and invasion of privacy. Will not make eye contact. Usually the resident/patient's eyes constantly slowly moving from the floor to ceiling and around the room. Staring into eyes of others is viewed as invasion of privacy, 	

Objective 12: Apply culturally appropriate verbal and nonverbal communication techniques when caring for members of the African American, Native American, Asian American, and Latino subcultures.

<u>Content</u>	<u>Notes</u>
<p>disrespectful, and may endanger spirits of both parties. Stares at floor indicates carefully listening</p> <p><i>Overhead – Show Overhead #13</i></p> <ul style="list-style-type: none"> • Touch – Resident/patient views firm handshake as aggressive and offensive. Best to pass hand with light touch • Silence – Highly valued, builds character. Believes one learns self-control, courage, patience, and dignity by remaining silent <p><i>Overhead – Show Overhead #14</i></p> <p>African American</p> <ul style="list-style-type: none"> • May be distrustful of the health care system • Health care provider should maintain professionalism and always address resident/patients by their last names, unless otherwise instructed. Calling resident/patient by first name or using such terms as “grannie” or “sweetie” may be viewed as disrespectful and racist • Distance – comfortable with physical closeness <p><i>Overhead – Show Overhead #15</i></p> <p>Latino</p> <p>Distance – more comfortable sitting close to the health care provider</p>	

Objective 12: Apply culturally appropriate verbal and nonverbal communication techniques when caring for members of the African American, Native American, Asian American, and Latino subcultures.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none"> • Many speak some English, but may have difficulty with medical jargon • When providing information, health care provider should speak with resident/patient slowly. May be embarrassed to ask for clarification or to ask the health care provider to slow down <p><i>Overhead - Show Overhead #16</i></p> <ul style="list-style-type: none"> • Disrespectful to call older adults by first name • Offended by a hurried manner • Eye contact - looks downward out of deference to age, gender, social position, economic status, and authority • Touch - accustomed to supportive touch and typically viewed as a measure of sincerity • Latino men generally protective of women and children. Want to be consulted in health care decision making • Latino men control emotions & do not reveal physical discomfort <p><i>Overhead - Show Overhead #17</i></p> <p>Asian Americans</p> <ul style="list-style-type: none"> • Health care provider is viewed as an authority figure • Distance - more comfortable positioned more than an arm's length from the health care provider • Tend to respond with brief, factual, answers because they value simplicity 	

Objective 12: Apply culturally appropriate verbal and nonverbal communication techniques when caring for members of the African American, Native American, Asian American, and Latino subcultures.

<u>Content</u>	<u>Notes</u>
<ul style="list-style-type: none"> • Older resident/patient often smiles, nods, and says "yes" even though he/she does not really understand what is being said. It is viewed as disrespectful to tell an authority figure (health care provider) he/she did not properly explain or demonstrate something • Tend to control emotions & not reveal physical discomfort <p><i>Overhead - Show Overhead #18</i></p> <ul style="list-style-type: none"> • Disrespectful to call older adults by first name • Seldom complain about what is bothering them. Health care provider must pay close attention to nonverbal signs of discomfort • Some resident/patients may consider it polite to only give a person the response the health care provider is looking for (misinformation may be obtained) <p><i>Overhead - Show Overhead #19</i></p> <ul style="list-style-type: none"> • Eye contact - View prolonged eye contact, as disrespectful, rude and invasion of privacy. Looking directly into eye implies equality. May avoid eye contact with health care providers (they are considered authority figures) • Silence - Viewed as a sign of respect for wisdom & respect for others. Silence is expected from young family members and those with less authority. Silence during a conversation may indicate speaker is giving the listener time to ponder what has been said, before moving on to another idea 	

Objective 13: Describe the culture of the healthcare system in our country & how it may conflict with values & beliefs of other cultures.

<u>Content</u>	<u>Notes</u>
<p><i>Overhead – Show Overhead #20</i></p> <p><u>Culture of our healthcare system</u></p> <p>Healthcare system is a culture with customs, rules, values, and a specific language</p> <ul style="list-style-type: none"> • Beliefs - standardized definitions of health & illness, believes in the power of technology • Practices - encourages maintenance of health (annual physical examination/routine diagnostic procedures) & prevention of illness • Prefers - promptness, neatness & organization, compliance • Dislikes - tardiness, disorderliness & disorganization • Customs - professional respect & admiration, obedience to power in bureaucratic system • Rituals - physical examination, surgical procedures, limiting visitors & visiting hours • Expectations - punctuality is an expected value including maintenance schedules, appointments, and rhythms of clock to organize the workday. <p>Individuals are expected to arrive for appointments on time</p> <p>African American, Latino, and Native Americans believe in completing the activity in which they are presently involved rather than interrupting it to keep an appointment. Being on time for them means arriving half-hour to an hour late for most of their business and social</p>	

Objective 13: Describe the culture of the healthcare system in our country & how it may conflict with values & beliefs of other cultures.

<u>Content</u>	<u>Notes</u>
<p>interactions.</p> <p>In some Asian cultures, it is considered impolite to arrive early or at the designated time.</p> <p><i>Written Activity - Distribute Written Activity #1 to participants.</i></p> <p><i>Discussion - Upon completion of Written Activity #1, discuss answers with participants.</i></p>	

WRITTEN ACTIVITY

For

***ADVANCED
COMMUNICATION***

Part 3

Advanced Communication

Part Three Written Activity # 1

Hello, I am Rosita from Mexico City. How will you talk to me? You may use your notes. You have 10 minutes to circle the correct answers.



1. Will you use long medical words in English? Yes or No
2. Will you speak very fast to me? Yes or No
3. Do you think I will make eye contact with you? Yes or No
4. Can my husband help me to decide what to do about my health problem? Yes or No
5. Do you think I will mind if you are in a big hurry to take care of me? Yes or No
6. Am I considered part of one of the subcultures of America? Yes or No

Hello, I am Chief John of the Cherokee Tribe. How will you talk to me? You may use your notes.



1. Will you use a firm handshake when we meet? Yes or No
2. Will you speak very loudly to me? Yes or No
3. Do you think I will make eye contact with you? Yes or No
4. Will I mind if you ask me questions in the busy lobby of the hospital? Yes or No
5. Do you think I will mind if you are in a big hurry to take care of me? Yes or No
6. Am I considered part of one of the subcultures of America? Yes or No
7. Will I mind periods of silence? Yes or No

1. Will I mind if you sit very close to me? Yes or No
2. When I answer your questions, will I go into great detail? Yes or No
3. Do you think I will make eye contact with you? Yes or No
4. Do I always understand something when I nod my head, yes? Yes or No
5. Do you think you will always be able to tell when I am hurting? Yes or No
6. Am I considered part of one of the subcultures of America? Yes or No



HANDOUTS

For

***ADVANCED
COMMUNICATION***

Part 3

Advanced Communication

Handout #1

Culture

Culture is a view of the world as well as a set of values, beliefs, and traditions that are handed down from generation to generation:

- Often foundation for language, communication style, customs, religion, health beliefs, and health characteristics
- Tend to share biological and physiological characteristics (some cultures at greater risk of developing certain health conditions/diseases)

Ethnicity is the bond or kinship people feel with their country of birth or place of ancestral origin:

- Based on socialization and not on biological traits
- Some people very proud of their particular heritage
- Examples, wearing certain items of clothing, giving children ethnic names, appreciating ethnic music, and eating native foods

Race is the biologic variation:

- Originally included four divisions worldwide – Mongoloid, Negroid, Caucasoid, and Australoid
- Based on differences in obvious physical features such as eye shape, skin color, and hair texture
- Racial mixing has blurred differences among races
- Important not to associate skin color with culture because it may lead to wrongly assume that all people with certain physical attributes share the same culture and have cultural values, beliefs, and practice different from those of the Anglo-American culture.

America's Culture & Subculture

Anglo-American is the dominant culture of America:

- Originated from western European countries
- Often described as white and Anglicized (English-based) because of the culture of early British settlers
- Not all people living in America accept the entire Anglo-American culture

Subculture refers to a unique cultural group that coexists with a dominant culture.

Major American subcultures based on ethnic background include:

- African American subculture
 - Originated from Africa, Haiti, Jamaica, West Indian Islands, and Dominican Republic
 - _____ of American population (1990 census)
- Latino subculture
 - originated from Mexico, Puerto Rico, Cuba, South America, Central America
 - ancestry is from Spain
 - _____ of American population (1900 census)
- Asian American
 - originated from China, Japan, Korea, Philippines, Thailand, Indochina, Vietnam, Pacific Islands
 - _____ of American population (1990 census)
- Native Americans subculture
 - included the North American Indian nation and tribes including Eskimos and Aleuts
 - _____ of American population (1990 census)

Cultural building blocks

Cultural sensitivity – when an individual becomes aware of, recognizes, acknowledges, and values that behavior patterns vary between and within ethnic groups

Cultural relativism – when an individual strives to understand the resident/patient's behavior within their own cultural system

Cultural negotiation – when an individual accommodates or modifies health care system to permit inclusion of health practices and beliefs into the plan of care

Cultural stumbling blocks

Prejudice – hostile attitude toward an individual because he/she belongs to a specific, racial, ethnic, or religious group

Ethnocentrism – the belief that one's own ethnic culture is the norm and superior to all others

Discrimination – differential treatment of an individual because he/she belongs to a specific, racial, ethnic, or religious group

Racism – is the combination of prejudice and discrimination

Stereotyping – is a fixed attitude, idea, opinion, or belief about all people who share a common characteristic, such as age, race, religion, or culture

Cultural imposition – imposing personal beliefs, values, and practices on another individual or group

Cultural blindness – seeing all cultures as the same

Cultural conflict – anxiety experienced when people interact with individuals who have different beliefs, values, customs, and languages than their own

Cultural shock – state of disorientation, confusion, frustration, and a feeling of helplessness produced by being in a culture different from one's own culture

Advanced Communication

Handout #2

Transcultural nursing

Transcultural nursing is nursing care provided within the context of another's culture:

- Culturally sensitive
- Accepts each resident/patient as an individual
- Based on knowledge of health problems that affect particular cultural groups
- Care planned with the resident/patient's health belief system in mind

Examples:

- Demonstrate respect for the resident/patient
 - Greet the resident/patient respectfully. Use title (Mr., Mrs., Miss) and the person's last name. Attempt to pronounce his/her name correctly. Health care provider should state his/her name slowly
 - Follow appropriate cultural preferences (eye contact, distance)
- Communicate in a non-threatening manner
 - Approach slowly and wait for acknowledgment
 - Project calmness
 - Allow time for responses and give resident/patient full attention
 - Try not to stand over the resident/patient, and when possible, sit at comfortable distance away from the resident/patient and lean forward. Do not interrupt. Avoid changing subject, nod occasionally, and acknowledge anxiety or fear
 - Provide the resident/patient with a quiet setting and privacy. May want family members present
- Adopt special approaches when resident/patient speaks a different language
 - Use a caring tone of voice and facial expression
 - Speak slowly and distinctly, but not loudly
 - Repeat message in different ways as needed
 - Focus on a single idea or experience
 - Allow silence
 - Note words that resident/patient seems to understand & use frequently
 - Keep messages simple and repeat often
 - Avoid medical terms and abbreviations. Pay attention to nonverbal behavior
 - Use a language dictionary if available

Advanced Communication Handout #3

Verbal & Nonverbal Differences Among Subcultures

Native Americans

- Rather private people. May be hesitant to share personal information with a stranger & often interprets questioning by the health care provider as nosy or meddling
- View listening as a valued skill & view impatience as disrespectful
- Note taking by health care provider - considered insulting because health care provider not paying full attention to the conversation, or suspicious because history preserved by verbal stories, rather than the written word
- Disrespectful to call older adults by first name
- May not speak up and say that a part of the conversation was not heard (considered rude or impolite)
- Low tone of voice is considered respectful
- Eye contact - prolonged eye contact is rude and invasion of privacy. Will not make eye contact. Usually the resident/patient's eyes constantly and slowly move from the floor to ceiling and around the room. Staring into eyes of others is viewed as invasion of privacy, disrespectful, and may endanger spirits of both parties. Stares at floor indicates carefully listening
- Touch - Resident/patient views firm handshake as aggressive and offensive. Best to pass hand with light touch
- Silence - Highly valued, builds character. Believed one learns self-control, courage, patience, and dignity by remaining silent

African American

- May be distrustful of the health care system
- Health care provider should maintain professionalism and always address resident/patients by their last names, unless otherwise instructed. Calling resident/patient by first name or using such terms as "grannie" or "sweetie" may be viewed as disrespectful and racist
- Distance - comfortable with physical closeness

Latino

- Distance – more comfortable sitting close to the health care provider
- Many speak some English, but may have difficulty with medical jargon
- When providing information, health care provider should speak with resident/patient slowly. May be embarrassed to ask for clarification or to ask the health care provider to slow down
- Disrespectful to call older adults by first name
- Offended by a hurried manner
- Eye contact - looks downward out of deference to age, gender, social position, economic status, and authority
- Touch – accustomed to supportive touch and typically viewed as a measure of sincerity
- Latino men generally protective of women and children. Want to be consulted in health care decision making
- Latino men control emotions & do not reveal physical discomfort

Asian Americans

- Health care provider is viewed as an authority figure
- Distance - more comfortable positioned more than an arm's length from the health care provider
- Tend to respond with brief, factual, answers because they value simplicity
- Older resident/patient often smiles, nods, and says “yes” even though he/she does not really understand what is being said. Is viewed as disrespectful to tell an authority figure (health care provider) did not properly explain or demonstrate something
- Tend to control emotions & not reveal physical discomfort
- Disrespectful to call older adults by first name
- Seldom complain about what is bothering them. Health care provider must pay close attention to nonverbal signs of discomfort
- Some resident/patients may consider it polite to only give a person the response the health care provider is looking for (misinformation may be obtained)
- Eye contact – View prolonged eye contact, as disrespectful, rude and invasion of privacy. Looking directly into eye implies equality. May avoid eye contact with health care providers (they are considered authority figures)
- Silence - Viewed as a sign of respect for wisdom & respect for others. Silence is expected from young family members and those with less authority. Silence

during a conversation may indicate speaker is giving the listener time to ponder what has been said, before moving on to another idea

Culture of Our Healthcare System

Healthcare system is a culture with customs, rules, values, and a specific language

- Beliefs - standardized definitions of health & illness, believes in the power of technology
- Practices - encourages maintenance of health (annual physical examination/routine diagnostic procedures) & prevention of illness
- Prefers - promptness, neatness & organization, compliance
- Dislikes - tardiness, disorderliness & disorganization
- Customs - professional respect & admiration, obedience to power in bureaucratic system
- Rituals - physical examination, surgical procedures, limiting visitors & visiting hours
- Expectations - punctuality is an expected value including maintenance schedules, appointments, and rhythms of clock organize the workday.
Individuals are expected to arrive for appointments on time

African American, Latino, and Native Americans believe in completing the activity in which they are presently involved rather than interrupting it to keep an appointment. Being on time for them means arriving half-hour to an hour late for most of their business and social interactions.

In some Asian cultures, it is considered impolite to arrive early or at the designated time.

OVERHEADS

For

***ADVANCED
COMMUNICATION***

Part 3

Definitions

Culture is a view of the world as well as a set of values, beliefs, and traditions that are handed down from generation to generation



- Foundation for language, communication style, customs, religion, health beliefs/ characteristics
- Tend to share biological & physiological characteristics

Definitions

Ethnicity is the bond or kinship people feel with their country of birth or place of ancestral origin:

- Based on socialization and not on biological traits
- Some people very proud of their particular heritage
- Examples, wearing certain items of clothing, giving children ethnic names, appreciating ethnic music, and eating native foods



Definitions

Race is the biologic variation

- Originally included 4

divisions –

Mongoloid,

Negroid,

Caucasoid,

Australoid

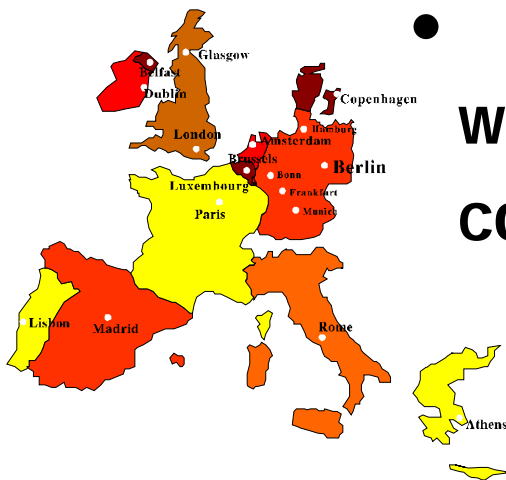
- Based on differences in obvious physical features

such as eye shape, skin color, and hair texture



America's Culture & Subculture

Anglo-American is the dominant culture of America



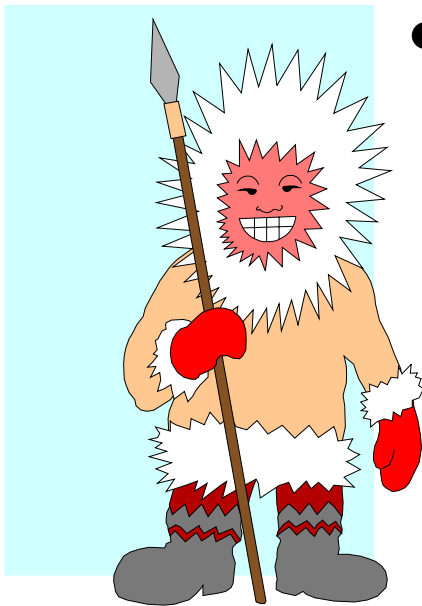
- Originated from western European countries

- Often described as white Anglicized (English-based) because of culture of early British settlers
- Not all people living in America accept the entire Anglo-American culture

America's Culture & Subculture

Subculture refers to a unique cultural group that coexists with a dominant culture.

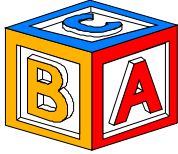
Major American subcultures based on ethnic background include:



- African American subculture
 - Latino subculture
- Asian American subculture
- Native American subculture



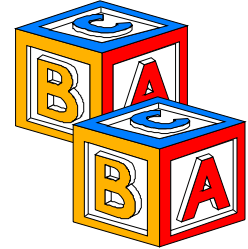
Cultural Building Blocks



Cultural sensitivity

Cultural relativism

Cultural negotiation



Cultural Stumbling Blocks

Prejudice

Ethnocentrism

Discrimination

Racism

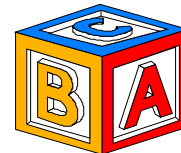
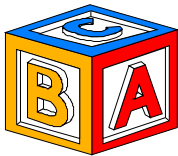
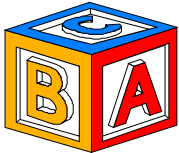
Stereotyping

Cultural imposition

Cultural blindness

Cultural conflict

Cultural shock



Transcultural Nursing

Transcultural nursing is nursing care provided within the context of another's culture

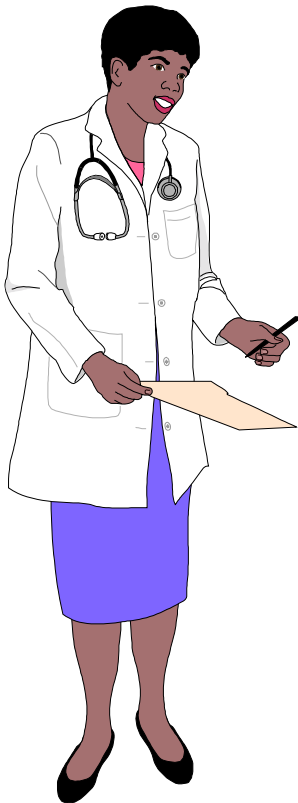
- Culturally sensitive - accept each person as an individual
- Based on knowledge of health problems that affect particular cultural groups
- Care planned with the resident/patient's health belief system in mind



Transcultural Nursing

Demonstrate respect

- Greet respectfully. Use title & person's last name. Attempt to say name correctly. State your own name slowly.
- Follow correct cultural preferences (eye contact, distance).



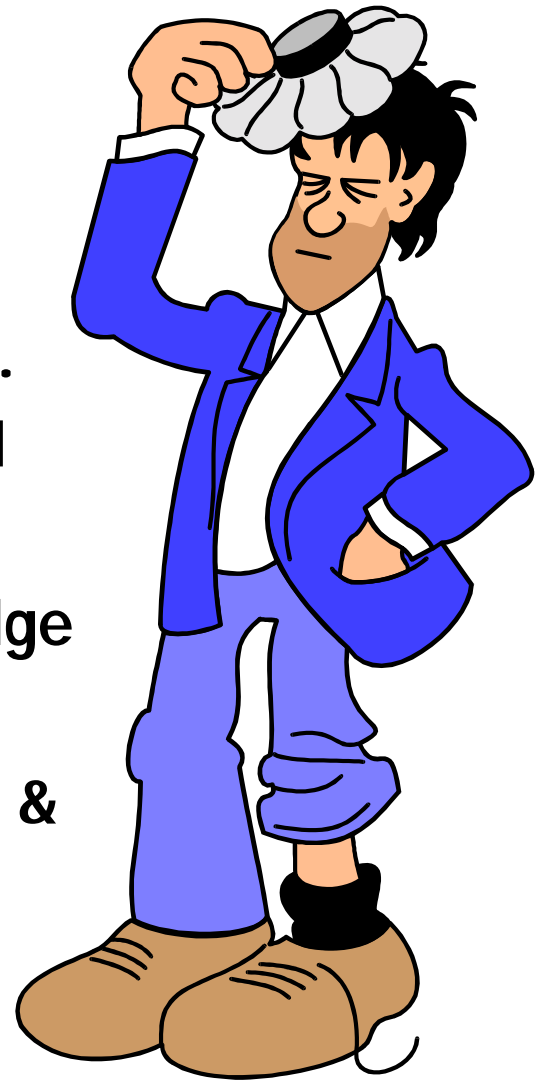
Communicate in a non-threatening manner

- Approach slowly and wait for acknowledgment
- Project calmness
- Allow time for responses and give full attention

Transcultural Nursing

Communicate in a non-threatening manner

- Try not to stand over & when possible, sit a comfortable distance away and lean forward. Do not interrupt, avoid changing subject, nod occasionally, acknowledge anxiety or fear.
- Provide a quiet setting & privacy. May want family present.



Transcultural Nursing

Adopt special approaches

- Use a caring tone of voice & facial expression**
- Speak slowly/distinctly, but not loudly**
- Repeat message in different ways**
- Focus on a single idea/experience**
- Allow silence**
- Note words that seem to be understood & use frequently**
- Keep messages simple/repeat often**
- Avoid medical terms/abbreviations**
- Pay attention to nonverbal behavior**
- Use a language dictionary if available**

Native Americans

Rather private people.

May be hesitant to share personal info.



**View listening
as a valued
skill & view**

**impatience as
disrespectful.**

Note taking considered insulting.

Native Americans

Disrespectful to call older adults by first name

May not speak up & say that a part of conversation not heard, low tone of voice is considered respectful

Eye contact – prolonged, is rude and invasion of privacy. Will not make eye contact.



Native Americans

A firm handshake is seen as aggressive & offensive.



Silence – Highly valued, builds character. Believed one learns self-control, courage, patience, and dignity by remaining silent.

African American

May be distrustful

Should maintain professionalism & always address by their last names, unless instructed. Calling by first name or using such terms as "grannie" or "sweetie" may be viewed as disrespectful and racist



Distance – comfortable with physical closeness

Latino

Distance – more comfortable sitting close to the health care provider.

Many speak some English, but may have difficulty with medical jargon.

When providing information, health care provider should speak slowly. May be embarrassed to ask for clarification or to ask the health care provider to slow down.



Latino

Disrespectful to call older adults by first name.

Offended by a hurried manner.

Eye contact - looks downward out of deference.

Touch - accustomed to supportive touch and typically viewed as a measure of sincerity.

Latino men protective of women and children. Want to be consulted in health care decision making.

Latino men control emotions & do not reveal physical discomfort.

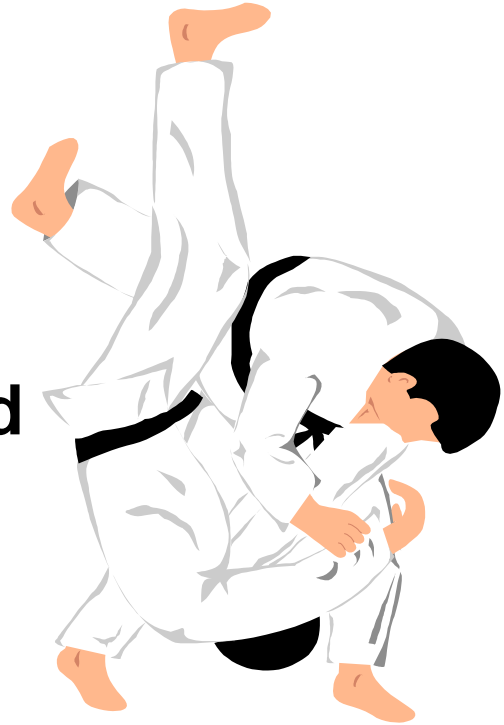
Asian Americans

Health care provider is viewed as an authority figure.

Distance - more comfortable positioned more than an arm's length away.

Tend to respond with brief, factual, answers because they value simplicity.

Older resident/patient often smiles, nods, and says "yes" even though he/she does not really understand what is being said.



Asian Americans

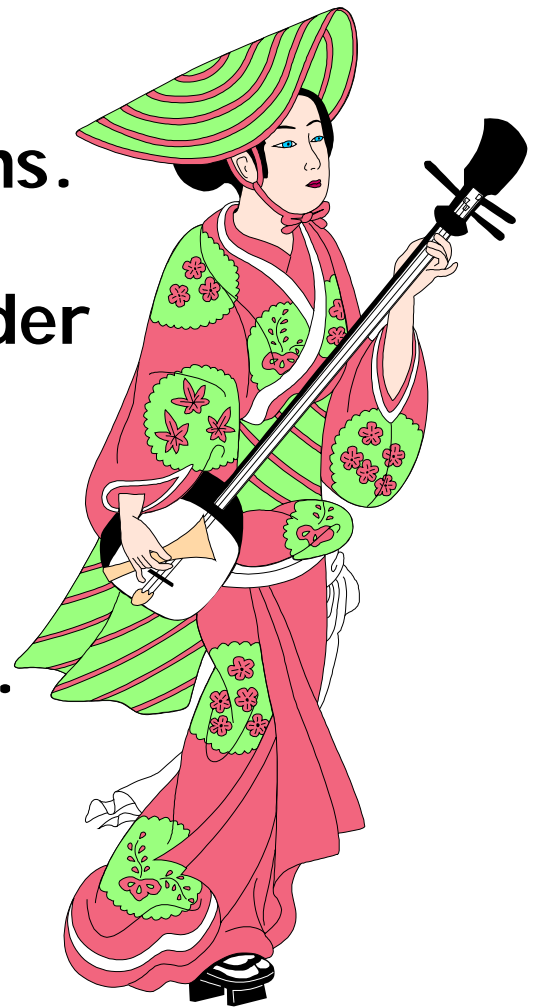
Is viewed as disrespectful to tell an authority figure (health care provider) that he or she did not properly explain or demonstrate something.

Tend to control emotions.

Disrespectful to call older adults by first name.

Seldom complain about what is bothering them.

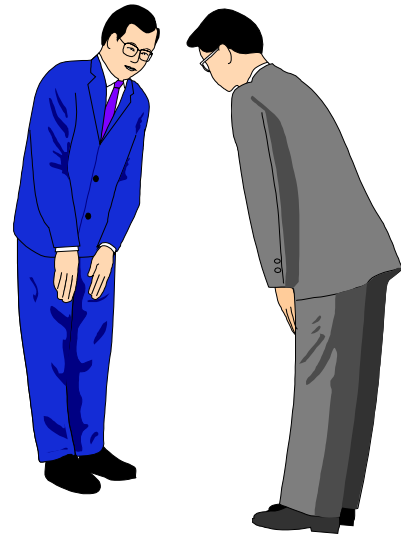
May consider it polite to only give a person response he or she is looking for.



Asian Americans

Eye contact – View prolonged eye contact, as disrespectful, rude and invasion of privacy. May avoid eye contact with health care providers (they are considered authority figures).

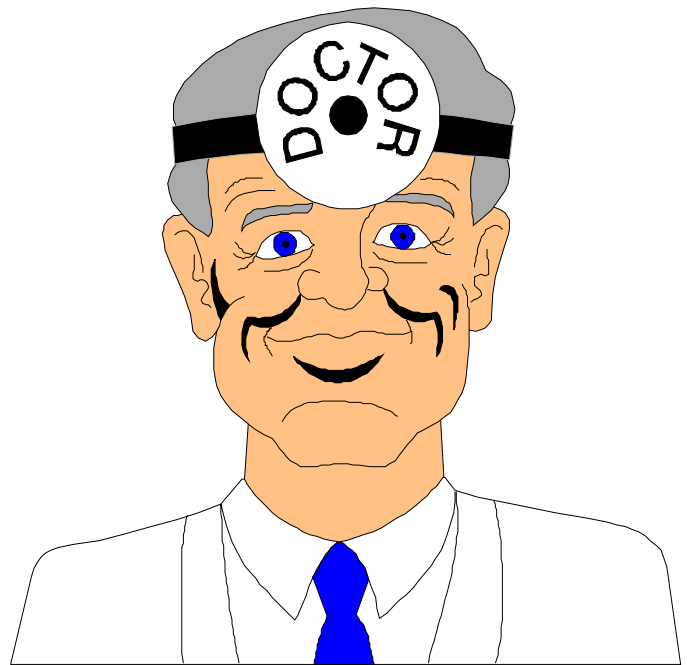
Silence – Viewed as a sign of respect for wisdom & respect for others. Silence may indicate speaker is giving listener time to ponder what has been said, before moving on to another idea.



Culture of Our Healthcare System

Our healthcare system is a culture with customs, rules, values, and a specific language.

- Beliefs
- Practices
- Preferences
- Dislikes
- Customs
- Rituals
- Expectations



Final Test

Name _____

Advanced Communication Skills Test

Answer the following questions. You may not use your notes or handouts. You have 30 minutes to complete the test.

Part 1. Match the term with the correct definition.

- | | |
|----------------------------------|---|
| _____ 1. Culture | a. a sudden, temporary state of confusion |
| _____ 2. Nonverbal Communication | b. exchange of information without words. |
| _____ 3. Touch | c. to cause a part of the body to come into contact without another object or person |
| _____ 4. Delirium | d. a view of the world as well as a set of values, beliefs, and traditions that are handed down from generation to generation |

Part 2. You are taking care of a patient/resident. Read each of the following statements and circle the statements that are therapeutic or the "right thing to say."

1. "If I were you, I would change doctors."
2. "Don't worry Sweetie Pie everything will be OK."
3. "You seem afraid."
4. "Your breakfast will be a little late today."
5. "How are you feeling today?"
6. "Oh, anyone can do that. What's wrong with your two hands?"
7. "George is assigned to your room. He would not have let your call bell ring for an hour."

8. "Don't worry. Be happy."
9. "Are **we** ready for **our** bath today?"
10. "I have 10 minutes. I f you would like, I will sit with you for a while."
11. "Why were you late today?"
12. "Uh Huh."
13. "I n my opinion, my charge nurse doesn't know what she is doing."
14. "This is the very best you have ever done. I 'm so proud of you."

Part 3. Read each of the following questions and circle the correct answer.

1. A sudden, temporary state of confusion.
 - a. Anxious
 - b. Depressed
 - c. Delirious
 - d. Unconscious
2. A person with a sad mood, has problems sleeping, and does not want to eat is most likely:
 - a. Depressed
 - b. A subculture
 - c. Unconscious
 - d. Hostile
3. Which one of the following groups of people is **not** one of the four main subcultures of America?
 - a. Native Americans
 - b. Russians
 - c. African Americans
 - d. Latinos

4. If I feel hatred for you, call you names, and threaten to kick you, I am being very _____.
- a. Depressed
 - b. Anxious
 - c. Hostile
 - d. Comatose
5. Which of the following is appropriate when caring for an unconscious resident/patient?
- a. "No need to talk to him, he can't hear anyway."
 - b. "Boo! I scared you! What's the matter, cat got your tongue?"
 - c. "Mrs. Jones, I'm going to turn you over on your side now."
 - d. Silence while caring for the resident/patient.
6. Which one of the following statements best represents the bargaining stage of "caring for a dying resident/patient?"
- a. "God, if you let me live to see my son graduate, I'll be ready to go."
 - b. "It's not true. She can't be dead!!!!!!!!!!!"
 - c. "Oh, why did I let her go to the store in the snow?"
 - d. "Dr. Bay, you killed her!"
7. Which one of the following activities is verbal communication?
- a. Saying the word, "boy"
 - b. Raising your eyebrows in shock
 - c. Tapping your toe against the floor frequently.
 - d. Waving at the person in the yard.

Advanced Communication Skills Test
Answer Key

Answer the following questions. You may not use your notes or handouts. You have 30 minutes to complete the test.

Part 1. Match the term with the correct definition.

- | | |
|---|---|
| <u> D </u> 1. Culture | a. a sudden, temporary state of confusion |
| <u> B </u> 2. Nonverbal Communication | b. exchange of information without words. |
| <u> C </u> 3. Touch | c. to cause a part of the body to come into contact without another object or person |
| <u> A </u> 4. Delirium | d. a view of the world as well as a set of values, beliefs, and traditions that are handed down from generation to generation |

Part 2. You are taking care of a patient/resident. Read each of the following statements and circle the statements that are therapeutic or the "right thing to say."

1. "If I were you, I would change doctors."
2. "Don't worry Sweetie Pie everything will be OK."
3. "You seem afraid."
4. "Your breakfast will be a little late today."
5. "How are you feeling today?"
6. "Oh, anyone can do that. What's wrong with your two hands?"
7. "George is assigned to your room. He would not have let your call bell ring for an hour."
8. "Don't worry. Be happy."

9. "Are *we* ready for *our* bath today?"
10. "I have 10 minutes. I f you would like, I will sit with you for a while."
11. "Why were you late today?"
12. "Uh Huh."
13. "I n my opinion, my charge nurse doesn't know what she is doing."
14. "This is the very best you have ever done. I 'm so proud of you."

Part 3. Read each of the following questions and circle the correct answer.

1. A sudden, temporary state of confusion.
- a. Anxious
 - b. Depressed
 - ☒ c. Delirious
 - d. Unconscious
2. A person with a sad mood, has problems sleeping, and does not want to eat is most likely:
- ☒ a. Depressed
 - b. A subculture
 - c. Unconscious
 - d. Hostile
3. Which one of the following groups of people is **not** one of the four main subcultures of America?
- a. Native Americans
 - ☒ b. Russians
 - c. African Americans
 - d. Latinos

4. If I feel hatred for you, call you names, and threaten to kick you, I am being very _____.
- a. Depressed
 - b. Anxious
 - ☐ c. Hostile
 - d. Comatose
5. Which of the following is appropriate when caring for an unconscious resident/patient?
- a. "No need to talk to him, he can't hear anyway.
 - b. "Boo! I scared you. What's the matter, cat got your tongue?"
 - ☐ c. "Mrs. Jones, I'm going to turn you over on your side now."
 - d. Silence while caring for the resident/patient.
6. Which one of the following statements best represents the bargaining stage of "caring for a dying resident/patient?"
- ☐ a. "God, if you let me live to see my son graduate, I'll be ready to go."
 - b. "It's not true. She can't be dead!!!!!!!!!!!"
 - c. "Oh, why did I let her go to the store in the snow?"
 - d. "Dr. Bay, you killed her!"
7. Which one of the following activities is verbal communication?
- ☐ a. Saying the word, "boy"
 - b. Raising your eyebrows in shock
 - c. Tapping your toe against the floor frequently.
 - d. Waving at the person in the yard.

Curriculum Module Evaluation

Evaluation Form for Instructor Advanced Communication Curriculum Module

Instructions: Please take a few minutes to complete the following evaluation. Read each statement and circle the response that represents your opinion about the curriculum module. Your responses and comments will help us improve the contents of the curriculum module, Advanced Communication. Thank you for your time.

Statements	Rating Scale				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does not Apply
1.The objectives were appropriate for the content.	1	2	3	4	0
2.The content was appropriate for the nurse aide's level of learning.	1	2	3	4	0
3.The Activity Worksheets were appropriate and complemented the teaching/learning process.	1	2	3	4	0
4.The role-play activities were appropriate and complemented the teaching/learning process.	1	2	3	4	0
5.Clinical practice was appropriate and complemented the teaching/learning process.	1	2	3	4	0
6.The handouts were appropriate and complemented the teaching/learning process.	1	2	3	4	0
7.The overhead transparencies were used, were appropriate and complemented the teaching/learning process.	1	2	3	4	0
8.The nurse aides will be able to use what they have learned in the work setting.	1	2	3	4	0
9.The nurse aides will be able to use what they have learned away from the work setting.	1	2	3	4	0

Please write additional comments in the space below:

What are the learning needs of the nurse aides employed at your facility?

Evaluation Form for Nurse Aide Advanced Communication Curriculum Module

Instructions: Please take a few minutes to complete the following evaluation. Read each statement and circle the response that represents your opinion about the curriculum module. Your responses and comments will help us improve the contents of the curriculum module, Advanced Communication. Thank you for your time.

Statements	Rating Scale				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does not Apply
1.The objectives were written clearly and easy to understand.	1	2	3	4	0
2.The content was appropriate for my level of learning.	1	2	3	4	0
3.The Activity Worksheets were helpful and helped me learn the content.	1	2	3	4	0
4.The role-play activities were helpful and helped me learn the content.	1	2	3	4	0
5.Clinical practice was helpful and helped me learn the content.	1	2	3	4	0
6.The handouts were helpful and helped me learn the content.	1	2	3	4	0
7.The overhead transparencies (if used) were helpful and helped me learn the content.	1	2	3	4	0
8.I will be able to use what I learned in the work setting.	1	2	3	4	0
9.I will be able to use what I learned away from the work setting.	1	2	3	4	0

Please write additional comments in the space below:

What other learning needs do you have?

Bibliography

Fuszard, B. (1995) Innovative teaching strategies in nursing. 2nd Ed. Gaithersburg, Maryland: Aspen Publishers, Inc.

Kozier, B., Erb, G., and Blais, K. (1997) Professional nursing practice, 3rd Ed. Menlo Park, California: Addison Wesley Longman, Inc.

Leahy, J. and Kizilay, J. (ed.) (1998) Foundations of nursing practice – a nursing process approach. Philadelphia: W.B. Saunders Co.

Lueckenotte, A. (1996) Gerontologic nursing. St. Louis: Mosby.

Kuckmann, J. (1999) Transcultural communication in nursing. Albany, NY: Delmar Publishers.

Matteson, M., McConnell, E. and Linton, A. (1997) Gerontological nursing – concepts and practices, 2nd Ed. Philadelphia: W.B. Saunders Co.

Potter, P. and Perry, A. (1997) Fundamentals of nursing – concepts, process, and practice, 4th Ed. St. Louis: Mosby Publishing Company.

Tappen, R. (1995) Nursing leadership and management: concepts and practice. Philadelphia: F.A. Davis Company.

Taylor, C., Lillis, C. and LeMone, P. (1997) Fundamentals of nursing – the art and science of nursing care, 3rd Ed. Philadelphia: Lippincott-Raven Publishers.

Timby, B., Scherer, J. and Smith, N. (1999) Introductory medical-surgical nursing, 7th Ed. Philadelphia: Lippincott Williams & Wilkins.